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How Expert Professional Nurses Practice and Develop Nurse Presence in a Critical Care Unit: A Grounded Theory Study

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HOW EXPERT PROFESSIONAL NURSES PRACTICE AND DEVELOP NURSE PRESENCE IN A CRITICAL CARE UNIT: A GROUNDED THEORY STUDY

By

Abigail Hain

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Abstract

The intent of this thesis was to increase understanding of the nurse's presence in clinical nursing practice within the critical care setting. Nurse presence is employed to achieve an enhanced connection with patients and has been described as both being there for and being with the other. Highly technological intensive care environments have the potential to objectify patients and present unique challenges to nursing professionals attempting to integrate this aesthetic art into their care.

Purpose: The purpose of this study was to examine how critical care nurses practice and develop nurse presence with their patients.

Method: Grounded theory method was used. Data were obtained from semi-structured interviews with nine expert critical care nurse participants.

Results: Presence as a practice emerged as a three phased process- commitment, presencing strategies and connection. The development of nurse presence as an evolutionary process was gradual, iterative and cumulative and was subject to two major influences- transitional influences and professional influences. Each patient experience with presence contributed to knowing the uniqueness of the individual as a whole person as well as to knowing a richer and deeper understanding of presence as a nursing practice. This integration of the practice and developmental components of this nursing phenomenon is described by the basic social process 'knowing the whole'.

Conclusions: Presencing emerged as a powerful and humanizing, aesthetic element of nursing the critically ill. Unlike previous studies on this concept, the grounded theory method revealed three stages of practicing presence and demonstrated that it is learned.

Acknowledgements

Nurse presence is not a term clinical nurse's use in their every day practice. Indeed when colleagues asked me what topic I was studying for this thesis work, I often took too many words to try to convey the essences of what this research was about. However, when the conversations turned to what was most important for nurses in connecting with their patients, explanations were no longer needed. Nurses know, value and often cherish the profound human connections they have experienced in being present to those they care for. I would like to thank my colleagues in the Intensive Care Units at The Ottawa Hospital (TOH) who inspired me to pursue this thesis.

Embarking on the completion of a thesis is somewhat of an adventure. The journey has been, at times, challenging and would have not been possible without the expertise, guidance and support of many individuals. I am grateful for the privilege to have worked with my thesis committee that was comprised of my Supervisor, Dr. Jo Logan, School of Nursing, Dr. Betty Cragg, School of Nursing and Riek van den Berg, Nursing Professional Practice (NPPD) at TOH. I would like to thank my thesis Supervisor Dr. Jo Logan for her expert guidance, perseverance and for always believing in this topic. This thesis has been shaped not only by Dr. Logan's expertise in academic research but by her obvious love of nursing as a profession. Dr. Cragg's thoughtful critique and skillful editing was invaluable in developing the final manuscript. Riek van den Berg's expert insights into the world of critical care nursing provided important contributions to this work, and her continued encouragement and support is much appreciated.

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Chapter 1

Introduction

How expert professional nurses practice and develop nurse presence in a critical care unit: A grounded theory study

" A long time ago someone said to me.. you know.. don't look at the machines, look at the patient.. that's how I look at technology in the ICU, always remembering that at the end of the machines there is a person"

The context and challenge

Today's tertiary Intensive Care Unit (ICU) is a highly technological health care environment. Sophisticated machines assist care teams in monitoring and providing life-saving care to patients and indeed, over-time, health care professionals in these areas have come to rely on technology to provide competent curative care (Locsin, 1995; McConnell, 1998). In light of this increasing emphasis and reliance on technology, the potential to miss a connection with the critically ill person's humanity becomes a reality for many critical care professionals (Marsden, 1990; Ray, 1998).

Communication challenges between nurses and patients related to the ICU patient's cognitive impairment, decreased level of consciousness, intubation, and sedation threaten the autonomy of the critically ill person, which can leave these patients vulnerable to objectification by their caregivers (Hupcey, 2000; Usher & Monkley, 2001).Also, patient and family satisfaction with care is gravely compromised when health care environments are impersonal and do not protect the dignity of a person (Attree, 2001; Walker, 2002). Despite the potential for impersonal nursing care in the technological environment of ICU, critical care nurses do succeed in providing caring, humanizing environments for the vulnerable, critically ill.

Nurse Presencing

Presencing is a strategy employed by nurses in challenging clinical situations to achieve an enhanced connection with their patients (Benner, 1984; Snyder, Brandt, Tseng, 2000; Usher & Monkley, 2001). Nurse presence is a developing concept that describes an important element of the nurse-patient relationship (Marsden, 1990; Snyder, Brandt, Tseng, 2000). The concept has been recognized as a sub-element of caring

practice and has been defined as a connection that takes place between a patient and a nurse in a reciprocal way: " To be present means to unconceal, to be aware of tone of voice, eye contact, affect, body language and to be in tune with the patient's messages" (Younger, 1995, p. 67). As Doona, Haggerty and Chase (1997) reveal in their exploration of nurse presence, "Nurses know that their presence, sometimes more than their techniques, is essential to caring for their patients" (p.5).

Presencing and Patient Outcomes

Schoenhofer and Boykin (1998) point out, nurses' contributions to outcomes in the ICU environment are often attributed to those measured from a "medical science vantage point" (p. 31). As such, caring, humanizing and empathic practices such as the intervention of presencing used by nurses are not as easily linked to tangible outcomes and therefore often remain invisible or are taken for granted (Benner & Shobe, 2004;). Clinical research is needed to understand this concept as it relates to nursing care (Gilije, 1993; Mohnkern,1992; Smith, 2002).

Unique connections and knowing. Presencing positions nurses to be in tune with their patients at a level that goes beyond physical signs and symptoms to acknowledge the patient as a whole person. Nurses who employ presence in their practice come to know their patients as individuals with unique needs, and as a result of understanding uniqueness can provide personalized, therapeutic interventions.

One of the most prominent needs of ICU patients that has been identified is the need to feel safe (Hupcey, 2000). Patients have described the nurse's presence as making them feel safe, valued, respected and comforted (Atree, 2001; Cronin, 1988; Gilije, 1992; Walker, 2002). Jenny and Logan (1992), in their research on knowing the patient, found

that presencing was a strategy employed by nurses to indicate caring and concern to their patients which in turn led to increased patient trust, comfort and "... the inclination to risk themselves to the care of the nurse" (p. 256).

Early problem recognition. A significant outcome found in the literature on nurse presence relates to the early recognition of patient problems- one of the main concerns of the critical care nurse (Benner, 1984; Doona, Haggerty and Chase, 1997; Minick, 1995; Mohnkern, 1992). Minick (1995) describes how the critical care nurse "presences with the patient" (p. 43) in order to make a connection with the patient's situation. This focused connection is what leads the critical care nurse to recognize subtle changes in patients' conditions. Minick points out that the knowing gained from presence is intuitive and embodied as opposed to a more tangible, cognitive and scientific knowledge. A relationship between intuition, clinical nursing practice and nurse presence was also noted by Mohnkern (1992) and was described by Doona, Chase and Haggerty (1999). Presencing allows nurses to connect with patients who may not be able to talk or interact. This focused attention takes the critical care nurse beyond the scientific data to pick up on subtle nuances in a patient's condition leading to personalized therapeutic nursing judgments and early problem recognition. Early problem recognition was described by Peden-McAlpine and Clark (2002), in their study of 15 expert critical care nurses, as a phenomenon where nurses are able to identify a change in a patient's status before the appearance of objective data to indicate a problem. This ability of expert clinicians is not clearly understood. What is noted by researchers in this field is the relationship between early problem recognition and nurse presence. This conceptual relationship identifies the concept of nurse presence as not only an important humanizing component of the nurse-

patient relationship and caring practice, but also as a concept that influences patient mortality and morbidity.

Despite these important patient outcomes, research that focuses directly on the understanding of nurse presence is sparse. Indeed, nurse presence as a concept is still underdeveloped (Smith, 2002). As well there are a significant number of ambiguities and contradictions within the conceptual development and research literature which will be discussed further in Chapter two of this thesis. These ambiguities point to areas for investigation. A philosophical debate exists as to whether nurses use presence as an intervention or are present as a way of being; this debate leads to implications for education because of the claim by some nurse scholars that nurse presence cannot be taught. How nurses cultivate or develop this skill is not understood and as such, studies are required to help clarify this issue. It is essential that more clinical research on nurse presence is pursued to allow for a greater understanding of this complex concept. In particular, a greater understanding of how nurses develop their ability to be present to their patients as whole persons is needed, not only in consideration of the human care component of professional nursing, but in recognition of the enhanced nursing judgments that lead to improved patient outcomes.

Research Question

The research question for this study is: How do expert professional nurses practice and develop nurse presence in a Critical Care Unit?

Objectives

The objectives of this study are to:

1. explore how expert nurses employ nurse presencing in a Critical Care Unit;
2. examine how expert nurses acquire skill in nurse presencing in a Critical Care Unit;
3. develop a conceptual ordering for the process of nurse presence in a Critical Care Unit.

Rationale

This research examines and describes how expert nurses practice and develop nurse presence in an ICU. It is anticipated that this research will contribute to the education of novice critical care nurses entering challenging ICU settings. Mohnkern (1992) briefly discusses a variation in the nurses' presence according to experience. She identified more experienced nurses as having an increased frequency in 'effortless moments of presence' with their patients- up to several times in one day. Presence in the nurse's practice cannot be simply reduced to years of clinical experience. However, by examining the developmental dimension of presence in expert critical care nurses valuable information can be offered to nurse educators who are teaching novice critical care nurses. Gaining an understanding of the profession's tacit, embodied, intuitive knowledge (Minik, 1995), as is the case with research into the clinical phenomenon of nurse presence, will contribute to both ontological and educational knowledge in critical care nursing.

Chapter One has summarized the direction of the research project. The potential for impersonal care that objectifies the vulnerable critically ill has been highlighted in the context of a high technology tertiary care environment. Nurses caring for patients in any area of acute care hospitals are challenged every day to maintain efficient and highly

competent care. These demands placed on nurses challenge caring practices that are at the very essence of what nurses do. High technology environments such as the Critical Care Unit further challenge critical care nurses in providing individualized, human care. This research project aims to increase the understanding of a caring, humanizing practice – that of nurse presence. A gap in knowledge about this nursing concept lies in understanding how nurses develop and practice nurse presence in the high technology environment of the Critical Care Unit. This research will address those issues, to further explicate this patient- centered concept.

This manuscript-based thesis will follow a detailed discussion of the current literature on the topic in Chapter two. Chapter three, in manuscript format, will discuss the findings of the first part of the research question: How do expert professional nurses practice presence in a critical care unit? Chapter four, in manuscript format, will discuss the findings of the second part of the research question: How do expert professional nurses develop nurse presence in a critical care unit? Chapter five will integrate the findings of the two part research question as well as expand on the ethics process and method. Additional discussion of the implications to practice, education and research along with the limitations of the study will conclude this thesis in Chapter five. Authorship credit is outlined in Appendix A.

Chapter 2

Literature Review

How expert professional nurses practice and develop nurse presence in a critical care unit: A grounded theory study

Literature Review

Morse (2003) comments that qualitative researchers should explore the literature broadly in order to "pragmatically and profoundly" (p. 840) argue their research proposal, although other expert qualitative researchers remind novice researchers that findings are grounded within the data and caution against taking too much direction from the literature to avoid affecting the rigor of their research. These researchers also note however, that for the qualitative grounded theory method, a review of the literature is an important step that will eventually contribute to data analysis (Holloway & Wheeler, 1996, Strauss & Corbin, 1998). Once data is collected, the grounded theory technique leads the researcher back to the literature to compare and contrast findings with previous research (Strauss & Corbin, 1998). The following is a review of nursing literature pertaining to the clinical nursing construct of nurse presence. The ambiguities and contradictions within the conceptual development and research literature on nurse presence (Doona et al, 1997; Chase, 2001; Smith, 2002) were explored and pointed to areas for investigation.

Research-based materials, as well as conceptual and philosophical literature on nurse presence were examined in this review. Related concepts, such as intuition, knowing the patient, caring and comfort, were also examined for their implicit or explicit relationship to the phenomenon under investigation. The search was conducted using CINHAL database with the following keywords and search terms: presence, nursing presence, nurse patient relationship, caring, and knowing the patient. English language articles between 1985 and 2006 were accessed. The reference lists of all retrieved articles were then manually searched for further material. This search strategy yielded 40 articles

related to nursing presence, of which nine were clinical research directed toward understanding nurse presence. Published clinical research on this phenomenon of interest to nursing is sparse; therefore unpublished studies accessed through a manual search of reference lists of retrieved articles and from a search of the Dissertations Abstracts database, were also included in the literature review when possible.

This literature review progresses from a discussion of the philosophical foundations of the concept to a review of the research on nursing presence. Conceptual models of nursing presence are then explored. Finally, an examination of related concepts highlights the complexity of this elusive concept.

Foundations of the Concept of Nursing Presence

Existentialism

Early epistemological questions regarding the nursing profession were put forth by Sister Madeline Clemence Valliot (1966), a French nursing philosopher, who described nursing as a profession without a philosophy of its own. She emphasized that nursing was indeed more than techniques and efficiency. Eventually, her pioneering vision outlined an existentialist philosophy for nursing in response to the profession's earlier reliance on the medical model which, she argued, emphasized techniques that could potentially objectify patients. Referring to the existentialist philosophies of Marcel and Heidegger, Valliot offered exemplars of an existentialist way of being in nursing which respects the being or humanity of others. Valliot's seminal work challenged the nursing epistemological foundations of the day and shifted the paradigm from a positivist norm to an existentialist alternative. Later scholarly work on the concept of presence

refers to these foundational writings by Valliot. The philosophical foundations of the concept nurse presence are aligned with an existentialist philosophy.

Nursing Theory

Paterson and Zderad (1976) incorporated an existentialist philosophy to their seminal work on the Humanistic Nursing Theory. These theorists linked presence to the nurse-patient relationship and defined nurse presence as "A gift of self that is conveyed through open and giving behaviours of the nurse" (p.132). In a shift from the positivist paradigm of scientific reductionism, Paterson and Zderad were also the first theorists to discuss the phenomenon of intuitive or empathic knowing in nursing in relation to nurse presence; acknowledging that nurses use something more than empirical, cognitive knowledge to care for their patients. They described the art of nursing using presence as an integral component of their theory of nursing. Other nurse theorists such as Parse (1992), Leininger (1981) and Watson (1988) have discussed nurse presence in their development of nursing theories. Parse acknowledges presence is the "primary mode of practice in nursing" and describes presence as " an interpersonal art that assists the patient to find themselves" (p.40). Leininger identified presence as one of the 99 constructs that define caring in her cross cultural study of the concept of caring.

The existential and theoretical roots of the concept of nurse presence place this phenomenon within a humanist, holistic framework. Respect of a person's being and humanity underlies the care by nurses in presence with their patients. Indeed the philosophical foundations of this concept are quite clear in the literature. What becomes more ambiguous is how nurse presence manifests in the application of nursing care. This challenge has led to lack of conceptual clarity and disagreement within the scholarship on

nursing presence. The philosophical dissonance that is emerging within this body of nursing literature relates to the tenet that nurse presence is an existential way of being and that a prescriptive application of presence is the antithesis of the foundations of the concept (Melenechenko, 2003). In other words, if nurses apply presence they are using a technique and, in doing so, risk objectifying the patient. A discussion of these recent philosophical ambiguities is included in this literature review

Research on Nursing Presence

Conducting research studies on the use of presence in clinical nursing practice is difficult because the use of presence requires subjective information from nurses and patients. Also, presence is often identified as an attribute or construct within other concepts of interest to nursing science such as caring, comfort and reassurance and as such, conceptual clarity concerning presence alone is elusive. Our enhanced understanding of presence in nursing frequently emerges from research looking at other related phenomena. However, as outlined in Table 2.1, the sparse clinical research on nurse presence, merits more clinical research on this important and elusive component of the nurse patient relationship.

Research Articles: Concept of Nursing Presence

Mohnkern (1992) and Gilije (1993) produced some of the first clinical research into the concept of nurse presence in their unpublished PhD dissertations. Mohnkern used a qualitative method of inquiry and conducted semi-structured interviews with a purposive sample of 15 expert nurses who practiced in various acute care areas such as medicine, obstetrics and critical care. The antecedents, attributes and consequences of presence are described in her work. Remaining aligned with existentialist philosophical

underpinnings that are the foundation of presence in nursing (Paterson & Zderad, 1976; Valliot, 1966), Mohnkern described nurse presence as an intervention. Mohnkern's interpretation of nurse presence as an intervention in nursing practice is similar to Benner (1984) and Gardner's (1992) view of this nursing concept as a sub-concept of caring. In Mohnkern's study, nurses described being present with their patients across varied acute care practice contexts, including critical care. These expert nurses identified that a sense of trust on the part of the patient and altruism or a desire to help on the part of the nurse were important antecedents to being present to the patients in their practice. Important nurse antecedents to presence included a nurse who feels an affinity for the patient, possesses "instinct, insight and intuition", is self-confident and mature and uses him or herself as a reference point to make care decisions (p. 123). A subtle but vital finding illuminated in this study was that patients invite the nurse to connect with them and the nurse achieves this through being present. In other words, there may be moments during a nurse- patient interaction where the patient has not indicated the need for a more in-depth, connected interaction with the nurse. An efficient transaction, such as the nurse checking an intravenous pump may be all that is needed. This finding is similar to Osterman and Schwartz-Barcott's (1996) as well as Easter's (2000) work on nurse presence models, in that the construct is described in nursing practice on a continuum of intensity and nurses are constantly using skilled judgment to determine a patient's particular need for level of intensity of the nurse's present connection.

Monkhern's findings on expert nurses gauging patients' need for nurse presence is key to the assumption underlying this research project: that a nurse's ability to be present in complex clinical contexts becomes more developed over time. According to

Benner (1984), a novice nurse is more likely to be absorbed in the clinical, practical demands of practice and has not developed the intuitive sensing that comes with experience and that is required of the nurse who is fully present to the patient as a person. Of note for the critical care context, Mohnkern speculates in her findings, that nurses caring for vulnerable populations such as children, the elderly or the critically ill assume these populations are inviting presence by their vulnerability.

The attributes of nurse presence described by Mohnkern were varied and were patterned on levels of intensity from a more simple need for physical closeness to a more complex metaphysical connection between two human beings that disregarded the roles of patient and nurse. Nurses described improved patient outcomes as a consequence of their being present to their patients, examples given were earlier mobilization and peaceful death. The nurses in this study reported that patients verbalized feelings of support, comfort and safety when the nurse was being with them in a present way. An additional consequence of nurse presence, from the nurses' perspective, was improved patient physical functioning, for example, in patients getting out of bed in response to the nurse's present coaching. Mohnkern also linked her findings to intuitive knowing, describing nurse presence as a phenomenon that often "precedes intuitive problem identification" (p. 169). In describing this dimension of nurse presence, the concept no longer exists singularly as an essential aspect of nurse-patient interaction, but becomes a subtle yet vital component of the expert assessments that nurses are constantly making in their practice. Mohnkern described nurse presence existing in this dimension as a focused connection to the patient that takes the nurse beyond quantitative data to sense subtle clues in changing patient conditions. The reciprocity and mutuality that exists between

the patient and the nurse when patients invite presence is not as clear in this richer conceptualization of nurse presence, which implies less of an interactional encounter. Minik (1995) also identified this dimension of nurse presence in her work on early recognition of patient problems, as did Doona, Chase and Haggerty (1999) in their work on nursing judgment.

Mohnkern (1992) acknowledged the risk to validity for her study in that nurse presence is a highly abstract phenomenon. To protect validity she used a variety of techniques including pilot testing of the interview tool, participant confirmation of data synthesis and audits to assess intra coder reliability and confirmability. The methodological and analytic processes for this study were meticulous and transparent. Limitations were related to nurses reporting patient findings from their perspective and, as pointed out by the researcher, the fit between a holistic concept and a linear approach to inquiry was difficult to achieve. Mohnkern's foundational work contributes to a greater conceptual clarity of nurse presence. How nurses acquire or nurture this at times elusive practice is not understood from her study. What is the process by which expert nurses come to know "effortless moments of nurse presence" in their practice? The research proposed by this project will attempt to illuminate and understand this aspect of nurse presence.

Gilije (1993) interviewed 15 outpatients from a mental health center using a phenomenological qualitative method. Her thoughtful and philosophical approach to the study of nurse presence offers substantive findings, contributing to a deeper understanding of the concept. Her research question focused on the meaning of the experience of nurse presence for patients. She attributed transformative experiences for

some patients to the nurse's presence. Three core concepts were derived from a synthesis of the data: 1. Enveloping comfort in the midst of discomfort affirms worth. 2. Heeding the call and inviting connection surface through the wellspring of love and authentic being and 3. Glimpsing possibilities is transforming, transcending time and space. Gilije offers an interpretation of the nurse's presence which is less aligned with the pragmatic interventionalist worldview. She concludes that being present as a nurse is "an artistic way of being that happens in meaning moments" (p. 175). She argues that nurse presence cannot be reduced to interventions and techniques. Unlike Mohnkern, Gilije suggests that nurses should be present with each and every patient interaction at the same level of intensity. She defines presence as "an enveloping comfort in the midst of discomfort" (p.156). Based on her research findings and philosophical interpretation of the concept, Gilije proposes the development of a middle range theory of nurse presence that would contribute to the ontology of nursing. This study is powerful in the sense that patient experiences with the nurse's presence are captured. Of note are the antecedent moments of vulnerability and loneliness that were described by patients experiencing the nurses' presence and the resolution of these feelings to feelings of comfort as a result of the nurses' presence. Generalizability of the findings may be limited as the study involved only mental health nursing care. By its very nature, mental health nursing is less physically interventional than critical care nursing. Physical nursing interventions have an increased potential to objectify patients. An objective of this study is to understand how critical care nurses employ presence in a high technology environment that involves many procedures and treatments.

Doona, Chase and Haggerty (1999) conducted a qualitative phenomenological study of nursing presence as it relates to nursing judgment. From their secondary analysis of 10 expert nurse narratives these researchers concluded that nursing presence is intimately linked to nursing judgment. These researchers outlined findings that suggested the nurses in the study were constantly present to and sensing the state of their patients, and that these nurses were present to this connection which led to their intuitive knowing. These findings are aligned with Mohnkern's (1992) suggestion that nurse presence is a connection to the patient that precedes the nurse's intuitive problem solving. The nurses participating in the study were practicing in obstetrics, critical care and mental health. Connecting, going beyond the scientific data, being with, knowing what will work and when to act as well as recognizing a patient's uniqueness were the themes derived.

The findings of this study support a central relationship between nurse presence and nursing judgments. The authors suggest that clinical judgments based in presence are different than intuition- or immediate possession of knowledge. Judgments based in presence are developed from a "bigger picture" that considers the whole patient situation.

The varied nursing contexts included in Doona and colleagues' study add an element of generalizability to their findings. A limitation is found in the method of secondary analysis. The researchers did not initially engage in the project to study nurse presence, but rather nursing judgment. The relationship to nurse presence arose inductively from the data. The qualitative method used for the study presumably contributed to a collection of rich data; however the interviews were focused on understanding nursing judgment rather than nursing presence. The authors also remarked on the limitations of a linear process of reporting research which compromises an

accurate description of a dynamic, holistic concept such as nurse presence. A model of nurse presence was developed by these researchers and is discussed later in this review.

Osterman and Schwartz-Barcott (1996) conducted field observation of the behaviours of nurse presence in a long term care setting. However, Osterman and Schwartz-Barcott did not outline the sample size, their time-period for observation, nor did they outline the coding of their observations in the interpretation of the nurse behaviours. Research ethics board approval was not indicated in this paper. The authors used their findings to develop of a model of nursing presence, outlined later in this review. While interesting, useful and indeed showing resemblances to other models of nursing presence, such as Easter's (2000), the questionable rigor of this research unfortunately undermines the researchers' attempts at conceptual clarity for the concept of nursing presence.

Four recent clinical studies on nurse presence have emerged between 2005 and 2006, indicating a motivation within the nursing research community to more clearly understand this holistic practice. The variety of specialty environments studied in this year speaks to recognition of the significance of presence in clinical practice. Caldwell et al (2005) conducted a study with 23 psychiatric nurses caring for seriously mentally ill clients in a US psychiatric hospital. The phemomenological design of the study sought to understand the lived experience of these nurses in establishing presence with their patients. Six themes were constructed to describe presencing: 1. knowing the uniqueness of individual clients, 2. listening actively with intense focus on the client, 3. engaging in several channels for change, 4. caring with confidence, creativity and perceived respect, 5. involving clients optimally and 6. encountering mutually effective change. Finfgeld-

Connett (2005), using a constant comparative method, had similar findings to Caldwell and colleagues in her study of 21 pre-natal, low income mothers in a smoking cessation program. The nurses supporting these mothers maintained a psychological presence, engaged in interpersonal reciprocity with a desire to work mutually with their clients and paid attention to the here and now. Finfgeld- Connett's findings also revealed expertness in presence in the nurse patient dyad, identifying that the presencing capacity for clinicians varies. She concluded that presence is a component of expert supportive nursing care.

Two of the four current clinical studies on nurse presence over the last year have added a significant contribution to understanding patients' experience of the nurse's presence. MacKinnon, McIntyre and Quance (2005) conducted a phemomenological study with 6 post-partum women. In seeking to understand the meanings women in labor attribute to the intrapartum nurse's presence during their childbirth experience, these researchers uncovered three ways the nurses were present- being there (physical presence), being with (emotional presence) and being for (advocacy). The meaning of the nurse's presence for these women was based on a relationship and getting to know and trust. Covington (2005) studied nurse patient dyads in her phemomenological study of patients (n= 10) with chronic illness and their nurse practitioners (n=5). In asking the question what is the experience of caring presence for patients with chronic illness as well as for their nurse practitioners, Covington developed three themes: 1. mutual trust and sharing, 2. transcendent connectedness and 3. metaphysical experience. Covington expanded on both nurses and patients ways of being and behaving in a present interaction. She described nurses' ways of being as: being available, open, goes beyond,

authentic and ways of behaving as: listens, reassures and does not judge. Patients' ways of being included: open and willing and ways of behaving included: being validated, feeling safe, comforted and nurtured.

The few existing studies of nurse presence reveal a relationship between nurse presence and aesthetic knowing, leading to enhanced problem identification, holistic nursing judgments and positive patient outcomes. In Rodgers (2000) exploration of the philosophical foundations of concept development she describes the dispositional theory of concepts which delineates conceptual clarity as the ability to formulate comparisons. The findings of the nurse presence research outlined in this literature review do lend to significant comparisons and similarities which is a promising development that moves the field closer to an increased understanding of this relevant nursing concept. However, research on nurse presence remains limited, and in particular the gap in our understanding of the development of the nurse's ability for presencing leads to the focus of this research project.

Conceptual Development of Nurse Presence

Model Development

Recently, nurses have attempted to conceptualize this concept using model development and literature synthesis. Literature on model and concept development is outlined in more detail in Appendix B. Osterman and Schwartz-Barcott (1996) describe four ways of being present- existing on a continuum from presence to transcendent presence while Easter's discussion paper (2000) describes four modes of presence as physical, therapeutic, holistic, and spiritual. Early problem identification, problem solving, patient reassurance, hope, connectedness, motivation, and courage are some of

the patient outcomes outlined by these two conceptual frameworks. Easter based her work on undisclosed research and as outlined earlier, Osterman and Schwartz-Barcott's observational research lacked rigour. However, the work done by both Osterman and Schwartz-Barcott as well as Easter have made important contributions to the understanding of the concept of nurse presence. Of note, both of these conceptual models interpret nurse presence on four levels of intensity, an interpretation that is consistent with Mohnkern's research that indicates not every nurse-patient interaction requires a profound and significant present connection.

Doona, Haggerty and Chase's (1999) model offers a comprehensive interpretation of nurse presence that outlines both the nurse's and the patient's affirmation in a present connection, supporting the attributes of reciprocity and mutuality that have been described in other work on nurse presence. Uniqueness, connecting with the patients' experience, going beyond the scientific data, knowing what will work and when to act, sensing and being with the patient are all component attributes of the concept identified from this study. These researchers do acknowledge the limitations of attempting to describe a dynamic concept such as presence within a linear research model. Chase (2001) argues in a later article that presence is not a cause and effect concept, however as she outlined in this conceptual model, nurse presence allows the nurse to judge what will work and when to act for the patient, presenting a seemingly cause and effect relationship in these attributes of the concept. The emerging ambiguities in the research literature on nursing presence have also directed the focus of this research initiative.

A research synthesis on presence, touch and listening by Fredriksson (1999) outlines two main sub-components of nurse presence, derived from 10 articles on

presence- being there and being with. Of the 10 papers on presence, 5 were conceptual discussions. The two sub-components derived from this synthesis were described by Fredriksson as "Being there", explained as an attentive attitude whereas "being with" was defined as something beyond the cognitive level - two people connecting beyond their roles of patient and nurse, a more connected interaction. Fredriksson derived a tentative model of the concept from his synthesis. He assumed that human beings are free to choose the way they want to relate and that patients indicate in their interaction with caregivers, their need for a more in-depth connection. He determined that patients choose to invite the nurse's presence in times of need and delineated a difference between the patient's invitation to "a connection (in-depth) versus contact (attention)" (p. 1174).

The three models outlined by Easter (2000), Osterman and Schwartz-Barcott (1996), and Fredriksson (1999) present the concept of presence on an interval continuum of intensity seemingly based on the needs and the invitation of the patient. The implicit assumption outlined within these models is that patients have differing needs for nurse presence and that nurses make decisions about the level of intensity of their presence based on an assessment of the situation and the patient. The fourth model developed by Doona and her colleagues (1999) is conceptually less linear but an interventional application of the concept still appears to emerge from the data in this study in the finding "knowing what will work and when to act". These preliminary conceptual models enhance the understanding of the concept. An interventional approach to nurse presence in practice is consistent with Mohnkern's (1992) findings in her study of the antecedents, attributes and consequences of nurse presence. It should be noted however that a great

deal of this conceptual model work is based on hypothesis and synthesis of conceptual literature, indicating a need for more solid research in this area of nursing practice.

A developmental model of presence that acknowledges the nurse's ability to develop skills in presencing was put forth by Godkin (2001). Expanding on Doona, Haggery & Chase's (1999) research on nurse presence, Godkin integrated a novice to expert model with Doona's and colleagues work, theorizing that presence as a practice can be developed in clinical nursing. Outlining her model of presencing development, while incorporating Benner's (1984) seminal work on novice to expert practice, Godkin theorized that novice nurses, while maintaining bedside presence, remained in the "lean domain of lay interaction" (p. 9) with their patients, in other words describing the novice nurse as offering presence in practice, but not at the same level of subtly, timing and intensity as an expert. She described that with experience and nurse task maturity, nurses moved through a "zone of transition" toward a richer, higher level of presence described by Godkin as healing presence. This hypothesized model has not been tested in the clinical arena.

Explicit clinical research that focuses on nurse presence is needed to further define the concept and to clarify existing ambiguity. The therapeutic value of nurse presence has been argued by nurse scholars, but a gap exists in understanding how nurses develop presence in the clinical environment. The objective of this study is to understand this process.

Dissonance in the Literature

A philosophical debate has emerged in the nursing literature on nurse presence, with one side of the debate aligning with the argument that nurse presence is a way of

being and the other side delineating nurse presence as an intervention that nurses choose to apply in their clinical practice. Doona and her colleagues (1997) describe presence as a concept that cannot be reduced to a nursing intervention. They posit that nursing presence is a philosophical way of being and, as a result, can be cultivated but not taught. According to Doona et al (1997) nurses do not use their presence, they are presences. Others have subscribed to this understanding of nurse presence (Drick, 2003; Gilije, 1992; Melenechenko, 2003). Melenechenko (2003) calls nurses to recognize the privilege in their connection with patients and critiques that much of the scholarship on nurse presence describes a subject-object nurse-patient relationship that is Cartesian in its thinking. In critiquing the existing work done, Melenechenko clearly subscribes to the argument that presence exists as an inherent capacity in human beings and that development of the ability for presence would be limited to the intensity of commitment and to the degree of natural ability.

Gardner (1992) on the other hand, describes nursing presence as a skill that nurses access, not unlike other skilled practices known to professional nurses. In this interpretation of nurse presence, Gardner acknowledges that there is room for learning and development of this skill in practice. She outlines the cognitive, affective and physical domains of nurse presence which may be applied as a nursing intervention in response to a nursing diagnosis. She describes direct surveillance, sharing, hope, comfort, empathy, support and nurse presence as constructs of the caring concept. Gardner has been critiqued by Donna and her colleagues for her pragmatic operationalization of the phenomenon. Her critics point out that presence as a concept is holistic and does not lend to a linear model such as the nursing process (Doona, et al 1997; Gilije, 1992). Benner

(1984) also describes nurse presence as an intervention in her extensive work with nurse experts across many clinical nursing contexts. She also acknowledges presence as an existential practice of "being with" the patient. According to Benner, nurse presence is one of eight competencies in the helping role.

Benner was the first nurse researcher to use the term nurse presencing - the application of presence in clinical practice. Like Gardner and Benner, Mohnkern's research leans towards the pragmatic aspects of nurse presence, these data reveal that nurses make decisions about the application of their presence in the clinical arena. Her findings also develop the concept further in linking expert nurse presence to intuitive problem solving, adding a dimension to the concept that is not clearly understood. Mohnkern argues that nurse experts do not follow the nursing process in a liner manner. She describes experts as making simultaneous evaluation of their interventions as practice. Her argument is expanded to recognize that in light of this non-linear application of the nursing process in expert nursing practice, nurse presence can be analyzed as a nursing intervention. It should be made clear that the pragmatic interpreters of this nursing concept do not stray from describing the existential roots of nurse presence. Each of these scholars acknowledges the philosophical foundations of this concept in clinical nursing practice, but also recognizes the applied skill that comes with expert nursing care. In other words, expert nurses make assessments of their patient's need for a closer connection and intervene accordingly. Unlike the purist critique of the interventionalist approach to nurse presence, the interventional pragmatists have not represented any reconciliation with the purist world view in the academic literature.

Explicit clinical research that focuses on nurse presence is needed to further define this concept and to clarify existing ambiguity, that is, does presence exist as an attribute of being human, as an inherent capacity or is presence a learned skill? The therapeutic value of nurse presence has been argued by nurse scholars, but a gap exists in understanding how nurses develop nurse presence in the clinical environment. The objective of this study is to understand this process.

Literature on Related Concepts

Knowing the Patient

Jenny and Logan (1992) identified an inter-relationship between knowing the patient and nursing presence in their study on understanding how expert critical care nurses wean patients from mechanical ventilation. Jenny and Logan indicated that presencing was a strategy employed by nurses to indicate caring and concern to their patients which in turn led to patient's increased trust, comfort and ".. the inclination to risk themselves to the care of the nurse" (p. 256). Presencing allowed these nurses to come to know their patients more fully and therefore plan individualized therapeutic interventions. Presence was also a prescribed intervention in this study. If a patient was particularly anxious, nurses made the decision to "be with" the patient as a strategy to decrease anxiety and increase the patient's confidence. In her discussion of the consequences of not knowing the patient, Whittemore (2000) outlines involvement on the part of the nurse in order to come to know a patient as a unique person. This involved stance leading to a knowing of the uniqueness of patients, describes nursing presence. Whittemore goes on to argue that a knowing of the unique patient is an essential component of nursing practice that leads to skilled clinical judgment and enhanced care.

Caring and Comfort

Caring and comfort research in nursing often leads to findings that describe the nurse's presence as being an important element in nursing care. Two qualitative studies, Attree (2001) (n=41) and Walker (2002) (n=17), challenged the traditional view that patients value competence over interaction skills. In both studies, patients identified human qualities such as being treated with dignity and as a human being as "good care" (Attree, 2001, p.458) or as "comforting" (Walker, 2002, p.44). Caring research has also investigated nurses' conceptualizations of what constitutes caring in professional nursing (Dryson 1996; Kapborg & Bertero, 2003; Moore, 2002; Nelms, 1996; Walter, 1995) these studies led to conclusions that include the nurse's presence as an important component of caring practice.

Intuitive Problem Solving

Minick (1995) found in her qualitative study of early patient problem identification in critical care nurses (n=30) that the nurse "presences with the patient" in order to make a connection with the patient's situation. This focused connection is what leads the critical care nurse to recognize subtle patient changes in condition. This finding is consistent with Doona (1997) and colleagues findings as well as with Mohnkern's (1992) work.

Literature Summary

This phenomenon has been aligned with increased patient comfort, earlier identification of patient problems, increased feelings of safety for the patient, humanizing technology, and patients feeling increased support and hope. In reviewing the limited research and the conceptual development literature on nurse presence, two somewhat

divided interpretations of this concept emerge. An existential purist view of presence sees this concept as a way of being that is non-causal nor interventional, emphasizing a subject-subject relationship that avoids objectification; whereas a pragmatic interpretation of presence allows for an application of a skilled intervention.

An important link to expert nursing also emerges from the literature. Experienced nurses who are fully present with their patients as persons are constantly gauging the patients needs. Experienced nurses use all of the data that is available to them to meet their patient's needs; this includes noting subtle cues that may not be accessed without an attentive, focused, present nurse. Nurse presence leads to enhanced nursing judgments, to insight and knowing beyond quantitative measurement of data.

The most in-depth research on nurse presence has been conducted for doctoral work. Each of the research findings from these studies, although based in similar philosophical underpinnings of existentialism, proposes somewhat different and indeed at times opposing interpretations of the concept. Mohnkern (1992) suggests nurses use presence as one possible intervention in combination with other nursing care interventions whereas Gilije (1993) concludes that to apply presence as an intervention is not truly being present as a way of being.

Some early attempts at conceptual development models (Easter, 2000; Osterman and Schwartz-Barcott, 1996), while helpful, are not based on rigorous research. Doona, Haggerty and Chase (1999) developed a model that was based on a more transparent research process. While their model does offer a more comprehensive interpretation of nurse presence, ambiguities arise in the authors' assertion that nurse presence is not a cause and effect phenomenon, although the model seems to outline a somewhat applied

description of nursing presence in clinical practice. Fredriksson's (1999) literature synthesis of the concept is innovative as well as useful in the production of a tentative model of nurse presence, defining a patient's self direction to 'connect' or when in need, for a more present 'connection'. Again, identifying the concept in nursing practice along a continuum of intensity from low to high, and interestingly pointing to a need for skilled patient assessment – expert nursing. Fredriksson's work is however, based only partially on research material due to the paucity of clinical studies on nurse presence.

An examination of the related concept literature highlights nurse presence as a complex component of aesthetic nursing knowledge, and that an overlapping in our understanding occurs as presence is revealed in related concepts such as knowing the patient, caring and comfort and intuitive problem identification. To date, ambiguities and contradictions in our understanding of presence exist in the nursing literature. It is anticipated that this study will contribute to increased understanding of this important component of holistic nurse-patient interaction.

The assumptions underpinning this study are based on the writer's experience as both a critical care nurse and as a critical care nurse educator. The influences of twelve years of experience in critical care nursing have shaped a view of presence that acknowledges nurse presence as an intervention that is applied thoughtfully by nurses and is a developed skill. These assumptions are borne from personal, novice experiences of being unsure how to connect with unconscious, seriously ill patients and being challenged to rapidly master technological competence over relational competence. Personal understandings of presence were gradual and were influenced by memorable patient experiences as well as mentoring relationships. Experiences in educating novice

ICU nurses as a clinical nurse educator have also influenced the development of the assumptions listed below. In the writer's experience, novices must spend a lot of time and energy learning critical care skills, at times to the exclusion of understanding or even noticing the patient experience at the center of all the technology. Over the past few years, the unprecedented burgeoning of technological innovations and techniques has presented an even greater challenge to ICU nurses in trying to maintain a human connection to their patients through their presence. In observing critical care nursing practice from these different perspectives it would seem that with clinical nursing experience and professional confidence, nurses gradually come to more fully understand the complexities of presence as well as the contributions being present to their patients can make. In other words, in my observations, nurses begin to increasingly incorporate presence as an applied intervention when needed, always maintaining an element of, perhaps less intense, professional availability.

Assumptions

The assumptions underpinning this study are:

1. presence is a sub-component of caring practices;
2. there is an increased challenge to be present to the whole person in high technology environments;
3. presence is learned and practiced by critical care nurses.

Operational Definitions

Nurse Presence is defined as a phenomenon that takes place during a human interaction. There is a connection that takes place between two people in a reciprocal way, where possible. A reciprocal connection may not always be possible because of influences on communication as seen for example in psychotic states and altered states of

consciousness. Presence enhances connection between the caregiver and the recipient of care. Presence can exist verbally or non-verbally through touch, eye contact or voice tonality. For presence to exist in this context there must be a focused intent to convey concern and be with the patient on the part of the nurse (Doona et al, 1997; Parse, 1995; Paterson & Zderad, 1979; Smith, 2001).

Critical Care Nurses are professionals who care for patients who are experiencing a life-threatening health crisis. Nursing the critically ill is continuous and intensive, and is aided by technology. Critical care nurses require advanced problem solving abilities, using specialized knowledge regarding the human response to critical illness. The critical care nurse is constantly challenged to provide comfort and to maintain the critical care patient's privacy in a highly technological environment (Canadian Association of Critical Care Nurses, 2004).

Intensive Care Units or Critical Care Units are described as areas that are designed specifically within a hospital setting to provide 24- hour, high-technology care to critically ill patients and their families. The environment is created to provide high visibility and ready accessibility to the critically ill patient. Varied technologies such as monitors, ventilators, intravenous pumps, dialysis machines, cooling devices and invasive monitoring catheters are used to care for the critically ill in the ICU.

Expert Nurses are defined as having specialized knowledge and skill in the science and the art of nursing. This specialized knowledge and skill is developed over time as the result of practice and exposure. "The expert nurse perceives the situation as a whole, uses past concrete situations as examples and moves to the accurate region of the problem

without wasteful consideration of a large number of irrelevant options" (Benner, 1984, p.295).

This chapter has reviewed the state of the science of nursing presence in a review of the literature. Ambiguities as well as developments in understanding have been outlined. The following two chapters in manuscript format will present the findings from this study as well as discuss the implications for practice, education and research. An expanded discussion of the consent and ethics process, methods as well as the implications for practice, education and research will conclude this thesis in Chapter five.

Table 2.1

Clinical Research Nurse Presence

Author *Article*	*Method* *Sample* *Country*	*Purpose of Study* *Description of Presence*	*Results* *Comments*
Caldwell, B., Doyle, M., Morris, M., & McQuaide, T. (2005) Presencing: Channeling therapeutic effectiveness with the mentally ill in a state psychiatric hospital. Issues in Mental Health Nursing, 26, 853-871	Qualitative Phenomenological Interview/unstructured Purposive sampling design N= 23 psychiatric nurses USA	Meaning of psychiatric nurse's lived experience of establishing presence with seriously and persistently mentally ill clients Presencing a dynamic process of knowing the uniqueness of individual clients. Presencing a strategic channel used by staff in creating therapeutic effectiveness	Listening actively with intense focus Engaging in several potential channels for change Caring with confidence, creativity and respect Involving clients optimally
Cohen,M., Hausner, J. & Johnson, M. (1994) Knowledge and Presence: Accountability as Described by Nurses and Surgical Patients Accountability, knowledge, phenomenology, presence Journal of Professional Nursing, 10 (3), 177-185.	Qualitative Phenomenological Interview/unstructured Purposive sampling design n=24 surgical patients n=24 surgical nurses USA	How nurses and patients perceive accountability Informants directed to discuss what was important to them related to their recent surgery and hospitalization Patients described presence as "attentive attitude" Nurses described presence as "getting to know the patient, establishing rapport, relating to each other as human beings"	Accountability was described by both nurses and patients as knowledge and presence Patients valued safety aspect of knowing nurse was available. Nurses valued more affective interpretations and identified barriers to presence such as lack of time
Covington, H. (2005) Caring Presence: Providing a safe space for patients. Holistic Nursing Practice, 3, 169-172	Qualitative Phenomenological Interview/unstructured Purposive sampling design N=5 nurse practitioners N=10 patients with chronic illness USA	What is the experience of caring presence for persons with chronic illness who are receiving primary care from an NP? What is the experience of caring presence for Nps giving care to persons with chronic illness? Presence: A way of being and relating	Three themes: Mutual trust and sharing Transcendent connectedness Metaphysical experience Model: Nurse- available, open, goes beyond, authentic, listens, reassures, does not judge Pt- Open, willing, validated, safe, comforted, nurtured
Doona, M. Chase, S. & Haggerty, L. (1999) Nursing presence: As real as a milky way bar. Journal of holistic nursing ,7 (1) 54-70	Qualitative Phenomenological Narrative interpretation Purposive sampling design N= 10 nurses, experts narratives Context: critical care, psychiatry, obstetrics USA	Analysis of nursing presence and delineation of its relevance for the nursing profession, particularly in relation to nursing judgment Nursing presence: An immersion in the whole situation, seeing beyond the immediate moment of the transition point to the possibilities inherent in the situation. A creative moment. Model Development	Model was developed from the themes: Tension in the moment Connecting with the patients experience Sensing Going beyond the scientific data Knowing what will work Knowing when to act Being with Nursing presence is intimately connected to nursing judgments

Author *Article*	*Method* *Sample* *Country*	*Purpose of Study* *Description of Presence*	*Results* *Comments*
Finfgeld-Connet, D. (2005) Telephone social support or nursing presence? Analysis of a nursing intervention. Qualitative Health Research, 15 (1) 19-29	Qualitative Grounded Theory Convenience sample N=21 women pre-natal, smoking cessation support group USA	Comparing definition of social support with nurse presence in the context of a smoking cessation support program for low income pre-natal mums	Components: Psychological presence Inter-personal reciprocity Therapeutic communication, attention to the here and now Expert nursing practice
Gilije, F. (1993) A phemoenological study of patients' experiences of the nurses' presence. Unpublished PhD Dissertation. University of Colorado Health Sciences Center	Qualitative Phemomenology Parse Method of Research Interview N=16 Convenience Sample Outpatients – Mental Health facility USA	Research Question: What is the structure of the meaning of the lived experience of the nurses' presence?	The nurses presence surfaces from love and authentic being and is experienced (by pt) as life transforming. The nurse's presence is foundational and central to caring and healing. Holistic – not compartmentalized Meaning (for patient) – the nurses presence is enveloping comfort in the midst of discomfort Philosophy- not an intervention
MacKinnon, K., McIntyre, M. & Quance, M. (2003) The meaning of the nurse's presence during childbirth. Journal of Obstetric, Gynecologic and Neonatal Nursing, 34 (1), 28-36	Qualitative Phemomenology N=6 post partum women Canada	To develop new understanding of what it means to women in labour for a nurse to be present during childbirth. Nursing Presence: Being there (physical presence) Being with (emotional support) Being for (advocacy)	The meaning of the nurses presence was based on a relationship and getting to know and trust their nurse Being for: act as a go between for their family and the medical institution
Mohnkern, S. (1992) Presence in nursing: Its antecedents, defining attributes and consequences. Unpublished PhD Dissertation. The University of Texas at Austin	Qualitative Symbolic Interaction Interview/Unstructured N= 15 participants Practice – mean 13.8 years Purposive sampling method- Snowball Expert Nurse- Peer identified Context – acute care USA	Research Question: What are the antecedents, defining attributes and consequences of nurse presence in nursing care as identified by professional nurses? Defined nurse and patient antecedents, attributes and consequences Identified caring, empathy, intuition and therapeutic use of self as related concepts in the literature review. Credible link to these concepts with own findings in the analysis of the research data. Challenge to the researcher in "fitting" a holistic concept into a linear model of research	Antecedents Patient trusts the nurse Nurse sense of altruism, insight and intuition about pt situation, vulnerable to patient situation, uses self as reference point, mature and self-confident Attributes Initial physical closeness, metaphysical connection and exchange between patient and the nurse Consequences Nurses report improved patient psycho-social-spiritual functioning, improved physical functioning or death. Nurse becomes surrogate for the patient. Personal and professional development for the nurse. A nursing intervention

Author *Article*	*Method* *Sample* *Country*	*Purpose of Study* *Description of Presence*	*Results* *Comments*
Osterman, P. & Schwartz-Barcott, D. (1996) Presence: Four ways of being there. Nursing Forum. 31 (2) 23-30	Field Observations Long-term care setting No sample size No demographic description No disclosure of data collection techniques No disclosure of analysis technique USA	To discover observational examples of nurse presence. Presence: Four modes of presence were observed and described. Presence, Partial presence, full presence, transcendent presence Model created	Presence: Physically present but self absorbed Partial presence: Physically present, mechanistic involvement in relation to the patient, solve problems. Full presence: Physically being there and psychologically being with. Focus on the patient. Professional relationship/role bound. Transcendent Presence: Physically, psychologically and metaphysically with the other. Holistic. Centered-oneness. Transcending the here and now. No roles, human intimacy, love.

Chapter 3

Presence: Coming to know the whole

How expert professional nurses practice and develop nurse presence in a critical care unit

This Chapter is based on the following unpublished manuscript

"She just looked needy...when her family left, she'd been chatting with her daughter...and you know she was very quiet and she kept looking at the door.. she looked nervous about being alone. You just get a sense of.. they need you there .. you know."

Abstract

Background: Nurse presence involves both being there for and being with the other and is employed by nurses in clinical situations to achieve an enhanced connection with their patients. Highly technological environments such as Intensive Care Units have the potential to objectify patients and present unique challenges to nursing professionals attempting to integrate this aesthetic art to their care. Currently, little is known about how nurses practice this element of holistic practice in Intensive Care Units.

Purpose: The purpose of this study was to examine how critical care nurses practice nurse presence with their patients.

Method: Grounded theory method was used. Data was obtained from interviews with nine expert critical care nurse participants.

Results: Presence as a practice emerged as a three phased process- commitment, presencing strategies and connection. Component parts of the phases included an initial sensing and engagement, followed by an application of strategies leading to a connected knowing of the patient and the human experience of being critically ill.

Conclusions: Unlike previous studies on this concept, the grounded theory method revealed three stages of the process of presence in practice. Presence was realized in ways of being – being there, being with, empathetic, authentic and ways of doing – advocacy, reassurance, support. Presencing in this context emerged as a powerful and humanizing, aesthetic element of nursing the critically ill.

Keywords: nurse presence, presence, critical care nursing, technology in health care, expert nursing, nurse- patient relationship.

Introduction

Despite the real potential for impersonal care in highly technological Intensive Care Units (ICU), critical care nurses succeed in creating caring, humanizing environments for the vulnerable, critically ill (Gramling, 2004; Locsin, 1995; Locsin, 1998; McConnell, 1998; Walters, 1995). All too often within technological ICU systems, value is placed on the visible, ignoring important intuitive and empathic aspects of skilled care giving (Bernardo, 1998; McBride, Robichaux & Clark, 2006). Nurses' contributions to outcomes in the ICU environment are often attributed to outcomes measured from a "medical science vantage point" (Schoenhofer & Boykin ,1998, p. 31). As such, caring and humanizing nursing practices are not easily linked to tangible outcomes and therefore often remain invisible or are taken for granted (Benner & Shobe, 2004). This paper presents the findings from a qualitative grounded theory (GT) study that examined how critical care nurses are present to their critically ill patients and illuminates how expert critical care nurses employ presence in their clinical practice.

Background

Nurse presence is employed in clinical situations to achieve an enhanced connection with patients (Benner, 1984; Snyder, Brandt, Tseng, 1990; Usher & Monkley, 2001). With roots in existentialist philosophy, presence has been linked to the nurse-patient relationship and to intuitive or empathic knowing and has been defined as "A gift of self that is conveyed through open and giving behaviours of the nurse" (Paterson & Zderad, 1972, p.132). Presence in the literature is referred to as a concept that describes an element of the nurse-patient relationship (Marsden, 1990; Snyder, Brandt, Tseng, 2000). The concept has been recognized as a sub-element of caring practice and has been

defined as a connection that takes place between a patient and a nurse in a reciprocal way (Gardner, 1985; Nelms, 1996).

Controversy in the literature has emerged on two points - learning presence and applying presence as an intervention (Smith, 2001). Although both sides of the debate are based in the existential philosophical underpinnings of the concept, one body of scholarship acknowledges that presence is a process recognized by nurses as a way of intervening for a patient in need (Benner, 1984; Covington, 2003, 2005; Gardner, 1992; Mohnkern, 1992). The opposing argument is put forth in describing nurse presence as a philosophical way of being that cannot be reduced to techniques of skill proficiency to be learned (Doona, Chase & Haggerty, 1997; Drick, 2003; Chase, 2001; Melnechenko, 2003). The concept of nurse presence appears in numerous philosophical concept analyses as well as in discussion papers, but few clinical research studies exist. The assumptions underpinning this study are aligned with the pragmatic interpretation that nurse presence is applied by nurses deliberately as an intervention. The influence of the researcher's experience as a critical care nurse has shaped these assumptions.

Method

Grounded theory (GT) methods (Strauss & Corbin, 1998) were used. GT method requires an investigation of the context, causal conditions, intervening conditions, strategies and consequences of a phenomenon.

Setting and Sample

The research was conducted in a 22 bed adult critical care unit within a three-site tertiary care hospital in Canada. A purposive homogeneous sampling design (Polit & Beck, 2004) was used to capture the components of the phenomenon of nurse presence

from the point of view of an expert group of ICU nurses. The homogeneous sampling decision provided a concentrated access to the phenomenon of interest and was also based on Mohnkern's (1996) findings that experts are more familiar with experiences of presence with their patients. Eight female and one male nurse each with at least five years of experience in critical care nursing and who fit Benner's (1984) definition of expert nursing practice were included in the study (Appendix D) (Table 3.1).

Procedures: Recruitment, Data Collection and Analysis

Following solicitation of leadership support for the study (Appendix E) and institutional ethics review board approval (Appendix F) the unit educators, using inclusion criteria outlined for the study identified the initial experts who would be interested in participating (Appendix G). The principal investigator then explained the study and obtained written, informed consent (Appendix H). Further recruitment was aided by expert peers using a nominated sampling technique, whereby recruited participants nominated peers that met the study inclusion criteria (Morse, 1991; Polit & Beck, 2004).

Data collection and data analysis were done simultaneously using the constant comparative method (Strauss & Corbin, 1998). Semi-structured participant interviews (Appendix I) were tape-recorded and transcribed verbatim. Transcribed copies were reviewed with the audiotapes for accuracy. The interviews ranged from 45 minutes to 90 minutes and took place either at the hospital or in the participants' homes, at their convenience. Analysis included three levels of coding- open, axial, and selective.

Rigour

The analytical process was supervised by a primary mentor and subject to an audit trail, research committee feedback, and mail out member checks to assess the validity of the findings (Appendix J). Participants received a copy of the abstracts and figures that were produced from the data. Confirmation of the findings came from eight of the participants in follow-up telephone interviews that lasted 10-15 minutes. One participant had moved from the area. As one nurse stated in response to viewing the representative figure of the practice of presence "This is how I feel about connecting with patients".

Results

The findings indicated the process of presence experienced by expert nurses and their perceptions of how it developed. This paper examined the processes. Nurse presence emerged as a component of the participants practice in the ICU. Three major categories or phases of presence: commitment, presencing strategies, and connection, as well as six sub-categories were found. Interconnections among the categories made the process of presencing in practice clear (Figure 3.1). Consistent with the GT method, a basic social process or core category, "coming to know the whole" was also identified.

Commitment

With a focused attention and a willingness to be involved with patient's being and experience, the participants were committed to a relationship with their patients. Without commitment, subtle patient cues could have been left unnoticed and potential moments of presence and connection could have easily passed by. Commitment to the patient emerged as a low intensity baseline of presence that was more or less constantly employed by the nurses. Participants noted that both respect for the patient and a

nonjudgmental approach were attributes of commitment. As one nurse described, being present and connecting to patients is something nurses "should do" and is a part of professional nursing care. The major category of commitment was comprised of two sub-categories: sensing and engaging.

Sensing.

Sensing included elements of intuitive awareness, perception and expertness. The participants acknowledged that sensing their patients' need for an enhanced nurse presence included being aware of two types of triggers: patient and context, but also having the skill and the ability to understand the triggers.

Types of triggers. Two types of cues triggered the nurses to engage further to an enhanced intensity of presence, resulting in increased data gathering as well as greater specificity in the selection of presencing strategies. Patient cues signaling a need for further engagement included aloneness, vulnerability, confusion, fear and uncertainty. One nurse described a situation in which she was caring for a young severely burned father who was expected to die, but was alarmingly aware of his surroundings. Despite limitations to communication from intubation and sedation, she recognized a need for enhanced presence and thus engaged in a reciprocally present moment with him. With tears in her eyes the nurse shared the following: "He would respond. He was able to open his eyes... he was able to blink and nod... and the only expression you could really see was in his eyes. You could see his fear. I asked him if he had fear and he nodded yes... and you could see... and [I asked]... are you afraid you are not going to make it?"

Contextual cues also evoked an increased intensity of the nurse's presence. End of life, invasive procedures and crisis moments such as ICU admission were all described as

contextual triggers. One nurse stated: "Think of being in a situation where you are totally powerless over anything that is being done to you, tubes, interventions, treatments, scans... without any sort of input from you. It's like we are taking... violating their most private thing... their body"

Understanding triggers. With a focused attention and a baseline intensity of presence, the nurses assessed the need for enhanced presence. They described constantly appraising the patient's status by integrating patient data from monitoring devices as well as attuning to subtle patient cues. Being present meant balancing multiple sources of data, trying to really understand the patient. One nurse described her integration of technology: "You can tell when something is changing even when it is very subtle. The heart rate is getting a little faster. The patient is maybe a bit more anxious or restless. They may be having more pain or anxiety, even just facial expressions...things like that, you can correlate both with your [vital] signs on the monitor and ... you can see a change in your patient's behaviour."

Engaging

Engaging in the moment was often an energetic, conscious decision. There was a moment of choice for the nurses, based on understanding triggers, a choice to deal with competing priorities such as medical tasks or to an engage more fully with the person. One nurse described an experience with engagement during the process of a cardiac arrest. As the patient roused from his unconscious state he briefly made eye contact and with fear in his expression mouthed around the endo-tracheal tube, "What happened?" " I stuck to what was important for him. At that moment he wanted to know what happened. If there is an alarm to be tended or a machine beeping... you say [to yourself]

wait a minute... listen to what his needs are... I mean his heart just stopped. So you can't walk away from that." This nurse prioritized meeting the need for an enhanced intensity of presence with the patient, over the fairly urgent technological demands of an ongoing resuscitation.

Not always. Adding a dimensionality to the category of commitment, the participants were able to share moments of their own vulnerability in that a connection with the patient was not always possible or desired. The choice to engage was not always initiated or sustained. For example the nurses were challenged in their choice to fully engage in connecting with patients who were angry and abusive to the care team or who were not open to a relationship with the nurse. On these occasions, the decision to step back and be available if and when the patient wished to engage was part of commitment for these nurses. Part of being present was being able to sense when one's presence was intrusive.

There were also instances where the nurses avoided fully engaging. This was evident in the occasional emotional distancing that took place in situations that were spiritually and emotionally distressing for the nurses. One nurse described: "I try not to get too close. Sometimes awful things happen and I couldn't bear it". Another stated barrier to commitment and subsequent engagement was workload for the nurses. Life saving care as well as managing large volumes of nursing and medical tasks on occasion interfered with being able to fully engage in connecting.

Strategies

In the second phase of the process, presence emerged as an intervention that was selectively applied in ways of being or ways of doing. This is depicted in Table 3.2.

Ways of Being

Being there. Components of this sub-category included physically being there with the person, letting the patient know that the nurse was available. Being there for confused patients consisted of re-orientation, comforting tone of voice and information about the surroundings. When asked to expand on her use of the term being there, one nurse described : "I think being there means just being a physical presence... someone to talk to or... sometimes when there is no family around just being a comforting presence... comforting to patients that they are not alone or you can get what they need."

Being with. In describing "being with" the patient context was often a highly charged emotional event where the patient was facing a great challenge for example ending life or fighting for life. A greater intensity and depth of connection was experienced in this way of being present and this depth of connection often left a lasting impression on the nurse. In describing her experience with a patient who would shortly die, one nurse in response to the patient's cue of fear, describes how she was "with" this patient as he was dying: "There was nothing I could do to take away all his pain or take away what happened... but I could be there to support him through it, to help him through it and to let him know his kids looked up to him as a hero because their dad died saving other people... That's how they [his children] left that day... thinking this."

Empathy. The nurses acknowledged achieving an enhanced connection and presence with their patients by relating to how they would feel in a similar situation or relating to their own life events. One nurse described the influence of being a mother in caring for a young mother with lymphoma and septic shock. "Being a mother yourself, you kind of relate to that and, you know, the kids coming in [to the ICU]... You kind of

feel like you are that person you know... You put yourself in that place...Your life is similar to theirs... You can relate very well to what is going on with them."

Authentic. Being with patients as a person rather than as a nurse allowed power dynamics to be rebalanced and mutual relationships to strengthen in rapport and trust. This authenticity took the nurses beyond professional boundaries that sometimes encouraged disengagement, allowing the nurse's authentic self to emerge. One nurse described caring for an older patient whom she recognized was becoming restless and frustrated at being in the ICU. She took the time to sit with him and share as a person. The patient settled for the night without any need for sedatives. " We started chit chatting... He was from my home town... He owned a hotel there... So did my great grandfather...and we started laughing... So we just sort of sat there... After a while I said, 'I can't stay for too long but it has been a real pleasure talking to you'."

Ways of Doing

Advocacy. Advocacy as a presencing strategy in this inquiry occurred frequently and often took the form of preserving the human dignity of patients in an environment that threatened it. The nurses' motivation for advocacy was to return power to the patients and involve them in their own care. The attributes of this category included being a voice for the patient to the multidisciplinary team when the patient and family were unable to speak or were absent. Also ensuring that the team included the patient, if she/he was able to interact in the discussion on rounds as well as navigating the system. One nurse describes this role in advocating for a long term patient with Guillain Barre (GB):"... He was sitting there for a month or so and no one was seeing him because he was chronic... and she said... you know there is a specialist for GB... He is nationally

known for this ... why don't you get him involved? He came, and within a month the guy was out of here, otherwise thought to be incurable. We also pushed for a primary physician."

Reassurance. Reassuring presence took the form of physically being closer to the patient, using reassuring words close to the patient's ear. Often reassurance was given during invasive procedures, walking the patient through a frightening experience by providing information in the form of step by step explanation. One nurse described her reassurance as helping both the patient and the family: "Initially the family is afraid to touch the patient ...afraid they'll pull the tubes and lines, they ask, 'Can I touch them, talk to them?' If they see you doing it, when you are walking by... just touching the patient's hand while you are doing something else, it reassures... it reassures the family. Sometimes it reassures the patient; for sure you can see the calming affect on the monitor, that the heart rate is not as high."

Support. Nurses were present to the ICU patients as coaches bringing the patients along in their recovery, helping them problem solve and, in the words of one of the participants, " setting the patients up for success" in their recovery. One of the nurses described normalizing the environment for patients: "I think when they [patients] are alert, helping them connect with what's going on outside them... Especially in the ICU where they don't know the time of day, ... they tend to get confused easily... so helping them keep busy during the day and , I guess...normalize a routine for them I think is really important."

In the second phase of the presencing process, nurses were selective in ways of offering presence to their patients. Patient uniqueness required the nurses to be creative

and the selection of presencing strategies was often based on the experience and professional confidence of the nurses. In this second phase, ways of being represented the affective, emotional component of presence as an intervention, whereas ways of doing represented the cognitive component.

Connection

From the initial commitment to the patient, involving a sensing and engagement, to employing individualized presencing strategies, the participants had outcome goals in mind. Comfort, healing and returning power to the patient were some of the identified goals. Ultimately, a connection with the unique person and/or the patient's experience occurred. Connection, as a major category in this study comprises the processes that allowed the nurses to come to know the unique patient or to come to know the patient's experience and humanity. The participants described finding satisfaction from their ability to connect with patients and families in this way. A reciprocal connection between the nurse and the patient was not always possible due to the unconscious state of many ICU patients, but barriers to communication did not prevent the nurses from connecting with the person as another human being.

An important iterative and cyclic dynamic to this process became apparent as the phases of presencing became clearer. That is, for the nurse, each patient experience informed the next. As the nurses came to know their patients, they were strengthened in their commitment, leading to an enhanced attunement to unique patient cues and contexts, further individualizing care, respecting the individual and deepening the intersubjective connection. In this understanding of presence as an iterative process that

becomes richer in coming to know the whole patient, an understanding of the holistic nature of artful presence is substantiated.

Knowing the patient

In connecting through presence, the nurses gained valuable knowledge of their patients' needs, response patterns, beliefs and values, motivations and desires. By knowing their patients' uniqueness, the nurses were able to individualize care. One nurse explained how she came to know a patient who survived septic shock: "She kept saying you know exactly what I need before I even ask for it...She had all her fingers and toes amputated so she couldn't hold a glass... I ended up progressing her to the point where she could go to the floor". This nurse in coming to know this patient, recognized independence as being an important value for her; this motivated the nurse to advocate relentlessly with the plastic surgery service to construct a modified dressing for the patient so she could hold a cup in her hands.

Knowing the humanity

In coming to know the patients' experience, the nurses were sensitive to the ICU environment as a potential threat to dignity and person. The connection experienced by the nurses in this context was a human connection. Over time and through experience, the nurses gained a richer understanding of the experience of being a vulnerable ICU patient. Through presence to the humanity of their patients, the nurses protected and, at times, revered the human being. Two components of this sub-category emerged – A person and dignity.

A person. Therapeutically paralyzed, intubated, sedated and unconscious patients were all noted to be especially vulnerable to objectification in the ICU and a special

effort was made with these patients to ensure a respect of the person. "... Having a paralyzed patient, you know... they are still there... they just can't respond to you".

Dignity. A protective stance was evident in the descriptions of preserving patient dignity. A preservation of dignity in life as well as in death was part of this connection to humanity. The nurses described how, if they were doing hands-on care, they were careful to maintain dignity and privacy. One nurse described her distress when she perceived patient dignity was being violated: "In a teaching hospital we do a lot of procedures when the prognosis of a patient is good and we know they are going to make it through... but why keep doing all the things we do when it [the prognosis] is not so good? ... We are invading in those last moments or days. This is what is lacking and threatens a patient's dignity"

The Core Category

For this grounded theory study, the core category or basic social process (Strauss & Corbin, 1998) "Coming to know the whole" represents the common thread that ran through the three phases of the presencing process. As each phase of the presencing process became more developed in the analysis, the central idea of the nurses seeing the whole emerged in each of these phases. In the initial phase of commitment, knowing the whole emerged in the nurses' integration of technological data with patients' patterns of response, seeing the whole patient beyond the technology. In the second phase, that of strategies, the core category became the nurses knowing what was needed and what would work, developing presencing from a richer well of experience. Knowing the whole for the third phase of the presencing process emerged as the nurses' understandings of uniqueness, as well as knowing the human experiences of suffering and vulnerability in

critical illness. In essence, as a common thread that enriched the understanding of these nurses impressions of presence, the basic social process of coming to know the whole refers to an evolving process of coming to know and understand the whole patient through presence. Coming to know the whole took on a transcendent meaning for the nurses in their descriptions of being a presence for their patients'. As one nurse shared: "You are not looking at the technology as much as at the whole person. You are looking at things as the bigger whole."

Discussion

The study results provide a description of what has been identified as an elusive component of nursing practice (Covington, 2003; Gilije, 1992, 1993; Smith, 2001; Stanley, 2002). The findings reveal: a) nurse presence existed as a process with three phases: commitment, presencing strategies and connection, b) in order to apply presence selectively, nurses relied on both patient and contextual cues, c) nurse presence existed with baseline intensity in the commitment phase and with an enhanced intensity, as nurses selectively applied their presence as an intervention, in the strategy phase. Unlike prior studies on this concept, which have used phenomenology, the GT method led to a description of presence that included a conceptual ordering of categories and ultimately to an increased understanding of how nurses actualize presence as a process in clinical practice.

The initial stage of commitment with an acknowledgement of a focused attention and a willingness to engage is congruent with the existential philosophical foundations of the concept of presence (Paterson & Zderad, 1976, Valliot, 1966). Cue recognition (Thomas & Fothergill-Bourbonnais, 2005) as an essential component of sensing

described in this study, is an important element of clinical nursing judgment and has been linked with "an engaged involvement and a connectedness to the patient" (p. 336). Sensing, sometimes coupled with an intuitive knowing, has also been recognized as a component of presence in the literature (Doona, Chase & Haggerty, 1999; Mackinnon, McIntyre & Quance, 2003; Senge, Scharmer, Jaworski & Flowers, 2004). New knowledge of this sensory attunement and subsequent cue recognition was revealed for the high technology environment. Not only were the nurses in this inquiry attuned to patient cues, they were sensitive to contexts within the high technology environment that had the potential to objectify. As well, the nurses came to rely on the integration of technological data into their assessment of the patient's need for presence, enhancing their ability to presence at an expert level. Engaging, as a choice point to further invest - enhanced presence, has been described and is similar to Doona, Haggerty and Chase's (1999) findings of "going beyond the scientific data", Benner, Hooper-Kyriakidis and Stannard's (1999) "skill of involvement" (p. 16) as well as Parse's (1994) "immersion". This study also contributes to the notion of nurses' decision not to fully engage as described earlier in this paper, in a component of the sub-category of engaging: not always.

The second stage of the presencing process – presencing strategies, illuminated the numerous ways nurses in the ICU were present in their practice and is congruent with Osterman and Schwartz-Barccott's (1996) work on levels of presence as well as Easter's (2000) modes of presence, in that presence manifests in a variety of ways, as well as in degrees of intensity, all dependant on the nurses attunement to the patient's needs. Melnechenko (2003) argues that much of the scholarship on nurse presence is based on a

Cartesian model of being human and that assumptions have been made by theorists and nurse scholars on this subject, "...that human beings are mechanistic and fixable, seeing the nurse patient relationship as subject-object" (p. 20). Melnechenko (2003) does not accept presence as an intervention; she argues that presence can only exist as a way of being. The results of this inquiry reveal that critical care nurses were present as a way of being, however deliberate presencing interventions were also selectively applied for specific patient needs. These findings substantiate the pragmatic interventionalist assumptions underpinning this study that, with a clear existentialist baseline, presence is an applied and developed skill.

Through an initial commitment and sensing, nurses offered their presence in ways of being and doing which led to a connected knowing, a process that appears similar to the U model of presence with it's components of sensing, presencing and knowing (Senge, Scharmer, Jaworski & Flowers, 2004). A connection with the unique individual and in a broader sense with the experience of being human resulted for these nurses. Knowing the patient and recognizing uniqueness has been frequently cited in clinical nursing research literature as an essential component of quality, expert nursing care (Attree, 2001; Jenny & Logan, 1992; Radwin, 1995). As well, coming to know the patient's uniqueness as a component of presencing is substantiated in much of the current research findings on nurse presence (Doona, Haggerty & Chase, 1999; Caldwell et al, 2005; Covington, 2005; Mackinnon, McIntyre & Quance; Mohnkern, 1992).

The results of this study are congruent with the clinical research on presence that exists to date. Being there, being with (Covington, 2005; Donna, Haggerty & Chase, 1999; Fredriksson, 1999; Gilije, 1993; Osterman & Schwartz-Barcott, 1996), empathy

(Mohnkern, 1992), authenticity (Cohen, Hausner & Johnson, 1994, Gilije, 1993) reassurance (Davis, 2005, Fareed, 1996) , advocacy (Caldwell et al, 2005; Covington, 2002; MacKinnon, McIntyre & Quance, 2003; Mohnkern, 1992) and support (Finfgeld-Connet, 2005; MacKinnon, McIntyre & Quance, 2003) are attributes of nurse presence seen in the recent clinical research literature concerning this concept. In this study these attributes were revealed as presencing strategies in ways of being or ways of doing.

Implications

These findings may be helpful in illuminating what can often be intimate and private experiences of critical care nursing practice. Nurses sometimes struggle to envision and value their unique contribution as a profession, particularly in practice environments that value analysis, technical procedures and tangible outcomes. By recognizing and valuing presence, an awareness of shared humanity and ultimately connection, may come to dominate the public sphere. Exemplars shared by the participants offer a tangible glimpse at what may have seemed intangible, and have the capacity to contribute not only to awareness and a valuing of presence, but also to the education of critical care professionals and the development of supportive clinical practice environments.

If nursing practice environments wish to support nurses in their presence, a philosophical recognition of the aesthetic art of nursing should be coupled with staffing ratios that enable nurses to develop relationships with their patients and families. Knowing the patient as the result of being a presence, leads to individualized interventions, improved patient and family outcomes and ultimately enhanced quality of care. The sensing component of the commitment phase of this study with cue recognition,

confirms the importance of nurse presence in early problem recognition (Minick, 1995) and clinical decision making, having significance to the patient safety movement which has recently gained momentum in tertiary critical care settings (Dodek, 2005; Valentin, et al, 2006).

Ultimately, an ability to truly presence and subsequently connect with patients contributes to meaning for nurses in their work, to believe that one is making a difference in someone's life surely contributes to nursing retention in a clinical area that has been attributed with high burnout (Poncet, et al, 2006; Sawatzky, 1996). Faas (2004) describes presence in critical care nursing as a journey with patients and families that is a gift to another that should be recognized and valued, as well as a practice that separates the practice of the expert nurse from the competent or proficient nurse. Presencing by nurses who are not practicing at the expert level should be studied. Do novice critical care nurses achieve presence in practice to the same degree as experts and what elements may contribute to a knowing of presence in practice? Questions for the discipline of nursing may include: How do expert nurses overcome barriers to being present in their practice? What is the meaning of the experience of the nurse's presence for ICU patients and families?

Conclusion

In this grounded theory study, nine expert critical care nurses shared their experiences of presence with seriously ill patients and their family members in an ICU. Presence emerged as a dynamic process comprising of three phases- commitment, presencing strategies and connection. Enhanced presence and ultimately a human connection resulted from expert sensing and a willingness to engage in the moment.

Presencing in this context emerged as a powerful and essential humanizing element of nursing the critically ill.

Table 3.1

Participant Demographic Data

Characteristic	Mean (n=9)	Range (n=9)
Age *(years)*	43	39-51
Number of years worked in nursing	21	16-27
Number of years worked in critical care nursing	17	9-27
Primary Language		
French	4	_
English	5	_
Nursing Education		
Diploma	6	_
BScN	1	_
BScN in progress	2	_
National critical care certification	7	_

Figure 3.1

Nurse Presence: Coming to know the whole

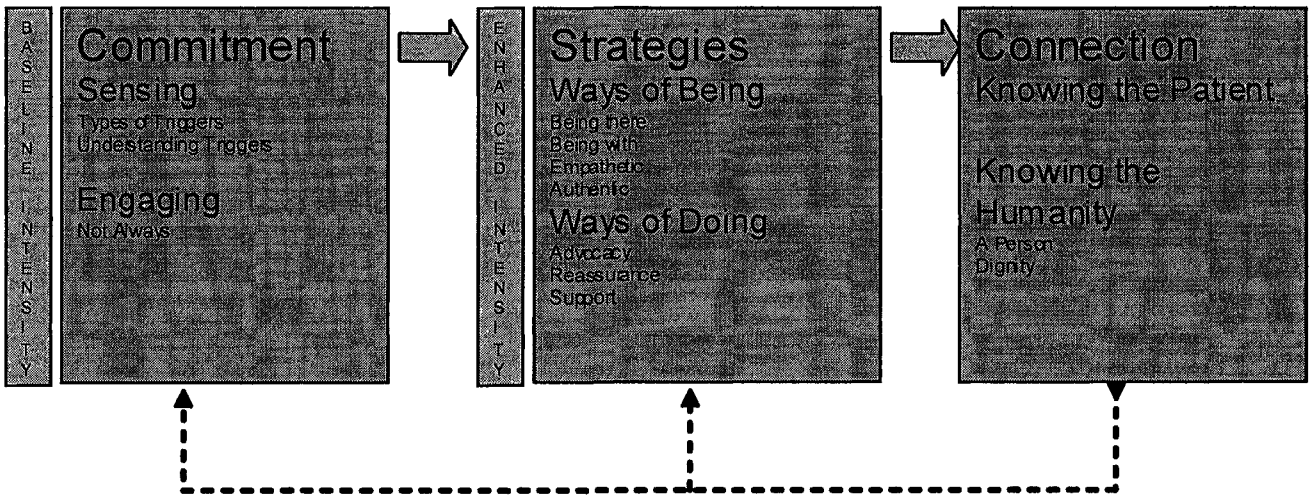

Table 3.2

Presencing Strategies: Skills in Practice

Strategies of Presence	*Skills in Practice*
Being There	Listening Sharing silences Going beyond the usual Caring Touch- hand holding Eye contact
Being With	Being fully available Sharing intense self energy
Empathetic	Relating to another's experience Relating to ones own life experience Sensitive and open Unconditional acceptance
Authentic	Sharing oneself Humour
Advocacy	Speaking for the other Honest information for the uninformed Knowing and sharing another's wishes Navigating the system
Reassurance	Eye contact Caring touch Speaking in soothing tones Information-what to expect Physically available
Support	Coaching Mutual goal setting Motivating Normalize

Chapter 4

How expert professional nurses practice and develop nurse presence in a critical care unit

Evolving presence: Coming to know the whole

This chapter is based on the following unpublished manuscript

"We did a wonderful job with this guy and we did this as a team. He made a miraculous recovery. We were there for him and we involved him socially in everything that was going on in the unit and gave him choices...it was great...we ended up being friends with him...you know

Abstract

Background: Presence is a concept that describes an element of the nurse-patient relationship. The concept has been recognized as a sub-element of caring practice and has been defined as a connection. Currently, little is known about how nurses learn and develop this essential element of holistic clinical practice.

Purpose: The purpose of this study was to examine how critical care nurses develop presence in their practice within a sometimes competing high technology environment.

Method: Grounded theory (GT) was used to describe the process of developing nurse presence in clinical practice based on interviews with nine expert critical care nurse participants.

Results: The development of nurse presence in practice was subject to two major influences- transitional influences and professional influences. The components of transitional influences were integrating technology, maturing as a nurse and life experiences. The components of professional influences were revealed as mentors and colleagues and practice reflection. A common thread or basic social process in GT – "coming to know the whole" emerged.

Conclusions: The study demonstrated that developing nurse presence is an evolutionary process. For the participants it was gradual, iterative and cumulative. Personal life experiences influenced the development of skillful presence in professional work. As well, technological competence emerged as an early but necessary transition in the critical care nurse's evolving presence.

Keywords: nurse presence, presence, critical care nursing, technology in health care, development of presence, nurse- patient relationship.

Introduction

Intensive Care Unit (ICU) nurses provide care to some of the most acutely ill patients in hospitals and must be well prepared to maintain skilled and knowledgeable care. Often, education for critical care nurses is focused on technological competence, with an emphasis on the most recent evidenced- based treatments.

Despite the potential for impersonal nursing care in the technological environment of ICU, critical care nurses succeed in maintaining caring, humanizing environments for the vulnerable, critically ill (Gramling, 2004; Locsin, 1995; Locsin, 1998; McConnell,1998; Walters, 1995). Nurse presence is employed by nurses in clinical situations to achieve an enhanced connection with their patients (Benner, 1984; Snyder, Brandt, Tseng, 1990; Usher & Monkley, 2001). Hain (Chapter 3, 2007) found presence to be a process comprised of three distinct phases: 1) commitment, 2) strategies and 3) connection. Within these phases, elements of expert assessment (sensing and cue recognition) as well as expert application (selectivity) of presencing strategies emerged, these data revealed a developmental component of learning presence in clinical practice. How then, do nurses in these high acuity areas develop an aesthetic knowledge needed to practice holistically? This paper will illuminate how expert critical care nurses develop nurse presence as a skilled practice.

Background

Nurse presence is a concept that describes an element of the nurse-patient relationship (Caldwell, et al, 2005; Covington, 2005; Gardner, 1992, Nelms, 1996; Marsden, 1990; MacKinnon, McIntyre, & Quance, 2003; Paterson, & Zderad, 1976; Snyder, Brandt, Tseng, 2000). The concept has been recognized as a sub-element of

caring practice (Gardner, 1992) and has been defined as a connection that takes place between a patient and a nurse, when possible, in a reciprocal way " To be present means to unconceal, to be aware of tone of voice, eye contact, affect, body language and to be in tune with the patient's messages" (Younger, 1995, p. 67). The concept of nurse presence appears in numerous philosophical, concept analyses, and discussion papers but few clinical research studies exist. Controversy in the literature has emerged on two points: learning presence and consciously applying presence as an intervention (Smith, 2001). Although both sides of the debate are based on the existential underpinnings, one body of scholarship acknowledges that presence is a philosophical way of being that cannot be reduced to learned techniques (Chase, 2001; Doona, Chase & Haggerty, 1997, 1999; Drick, 2003 ; Gilje, 1992; Melnechenko, 2003). The opposing argument is put forth in describing nurse presence as a way of intervening for a patient in need and is therefore, as an intervention, teachable (Benner, 1984; Covington, 2005; Gardner, 1992; McKivergin & Daubenmire, 1994; Mohnkern, 1992). No studies on how nurses develop nurse presence as a skilled proficiency were found.

Method

Grounded theory (GT) methods as described by Strauss and Corbin (1998) were used in this qualitative study. This sociological research method assumes that reality is not constant, and that meanings change and are modified. In researching the developmental component of nurse presence, a process, as well as potential changed meanings for nurses in relation to their application of presence over their years of practice in ICU, is implied. GT allows for a description of stages over time and recognizes that

meaning for individuals may change as experience is gained. Therefore the GT method was appropriate for this project.

Sample and Setting

A purposive homogeneous sampling design (Polit & Hungler, 1997) was used to capture the developmental components of the phenomenon of nurse presence from an expert group of ICU nurses. Data saturation delineated the final sample size and comprised one male and eight female nurses, with a range of nine to twenty-seven years of experience in critical care nursing and who fit Benner's (1984) definition of expert nursing practice (Appendix D) (Table 3.1). The study was conducted in a 22 bed tertiary care ICU in Canada.

Data Collection and Analysis

Following research ethics board approval (Appendix F), the ICU educators and expert peer participants, using a snowball method of recruitment, nominated experts who were interested in the study (Appendix G). Once the study had been described to the participants, an informed consent was obtained by the principal researcher (Appendix H). Data sources consisted of semi-structured interviews which were tape-recorded and transcribed verbatim (Appendix I). Transcribed copies were reviewed with the audiotapes for accuracy. The interviews ranged from 45 minutes to 90 minutes and took place at the hospital or in the participants' homes at their convenience.

Data collection and data analysis were done simultaneously using the constant comparative method (Strauss & Corbin, 1998). Analysis included three levels of coding-open, axial and selective (defined in Chapter five). Data was coded and major categories with sub-categories were developed. Relationships between the categories emerged and a

central process was identified. Supervised by a primary mentor, the analytical process was subject to an audit trail, research committee feedback and mail out member checks, followed by one telephone call to confirm findings (Appendix J). Identification of process and developmental components of presence was achieved; this paper deals with the development of presence in clinical nursing practice.

Results

The participants described the development of skilled presencing in their nursing practice as an evolutionary process (Figure 4.1). The nurses acknowledged that their skill in incorporating presence was a component of their practice that developed gradually, in response to certain experiences and influences. Two major influences emerged from the data: transitional influences and professional influences. A central category was also developed, that of "coming to know the whole". An identification of a basic social process (BSP) or "central category" is part of the GT method (Strauss & Corbin, 1998, p. 146). As an explanation of what developing presence is about for the critical care nurses in this study, "coming to know the whole" pulls the development categories together into one central idea. In learning how to presence over time, the participants were exposed to influences that contributed to their appreciation and understanding of presence in clinical practice; "coming to know the whole" as a core category, describes the nurses evolution towards a deeper and richer understanding of how to presence, as well as gaining an appreciation for the art as well as science of nursing care. In earlier descriptions of the process of presence (Chapter three), coming to know the whole as the central category, refers to an evolving process of coming to know and understand the whole patient through presence. By integrating the two components of this study

(Figure 4.2): understandings of the practice and the development of presence can be brought together with this core category forming an explanatory whole.

Transitional Influences

Three distinct transitional influences emerged as the evolutionary process of developing presence in practice was more clearly elucidated over the course of the study: integrating technology, maturing as a critical care nurse, and life experiences.

Integrating Technology "Gaining Confidence"

Integrating technology occurred as nurses became comfortable with the technology and techniques of critical care nursing. Integrating technology as part of the critical care nurse's evolving use of presence emerged as a two stage process- overwhelmed by technology and beyond technology.

First, the participants described feelings of being overwhelmed and even fearful in the first few months of caring for patients. Not only were they preoccupied by the numerous psychomotor skills but also by the volume and the pace of the work. One nurse described her novice practice: "You're not looking at the holistic thing. You are looking at every little thing in a systematic way. All you are dealing with is the illness the typical illness. You're not looking at the patient, you're not looking at the family or the other needs".

A need to acquire strong technical skills as well as stay on top of the complex tasks and physiologic data precluded the nurses from attending to humanizing and empathetic actions needed by the patient's experience. Study participants frequently stated that finally after a few months of nursing in the ICU they remembered actually noticing that there was a patient in the bed.

Secondly participants described moving beyond the overwhelming focus on technology to an integration of the technology into nursing care. The participants described a transition point in appreciating that technological care should not always take priority. As confidence in technological competence was gained, skills in patient cue recognition began to develop along with a sensitization to contextual triggers that indicated patients' need for an enhanced nursing presence. For example, "It took a while, but then at a certain point you felt a little more confident, you got familiar with the equipment so it was less intimidating. Then you can focus on the actual care you are giving. When the machines are no longer important, we can deal with the emotions of the patient, the family and friends."

Recognition of both contextual and patient triggers sensitized the nurses to being fully present to their patients but this came only with time and experience. Contextual triggers such as end of life, admission to the ICU, invasive procedures, and in general, the patients' loss of autonomy alerted the nurses to presencing. Particular patient cues were also described as triggers to presence, cues such as facial gestures, certain questions and emotions; fear in particular and sometimes just "a look". Being able to see beyond technology enough to recognize and understand these triggers was an important first step for the nurses in their evolution toward a more expert development of presence in their overall nursing practice in the ICU. Coming to know the whole as the core category, explains the understanding the nurses realized at this point; that the care of the critically ill involved more than technological competence. Rather, skills in cue recognition, seeing the patient holistically and being able to meet all the patients' needs, including emotional

ones, were identified as equally important as the nurses gained technological experience and confidence.

Maturing as a Critical Care Nurse "Growing"

As they reflected on their practice over the years, the second transitional influence for the participants was recognized as maturing. A richer recognition of the whole patient experience (coming to know the whole) as well as a confidence in what they could offer to patients and families in terms of their presence was echoed by more than one participant. This transition in the nurses' growth as professionals appeared as something more profound than simply seeing beyond the technology of the environment. One participant with over twenty years of experience as an ICU nurse shared: "I guess at one point there is a transition and you say... ok... it is nice to have a stable patient, it's nice to have a patient you can have a conversation with. When that transition occurs, I don't know. I guess it is something we realize as professionals. I think it is a natural progression. In speaking to my colleagues... I think a lot would say leave those crashing patients with the Swan [Swan-Ganz] catheters for the young kids, we've been there, done that".

Connecting with presence to family and to the critically ill patients did not come automatically. A lack of confidence in these abilities was recognized as a barrier to presence. Confidence in their own ability to offer presence in being with their patients was at times recognized as a source of satisfaction for the nurses. One nurse described this development of confidence in his ability to offer presence: "I think I am a lot more comfortable with the death of a patient... I just feel more at ease with it... its part of life really and if you can make it more comfortable for that patient... this is where you get

satisfaction. If you can help them die, make them more comfortable and just be with the patient and family... ultimately the patient dies and life goes on.

Life Experiences "Relating"

The study participants also recognized the influence of their own key life experiences on their growth as people, noting that these personal life experiences influenced their connectedness to their patients and their ability to relate to patient experiences. Common life transitions such as caring for aging parents or mother-hood influenced these nurses in their presence with patients in the ICU. One nurse described the influence of the loss of her own family member on her practice: "After, it hit home... I kind of looked at things in a different perspective... It personalizes it more maybe...He [the patient] could be a father of kids, a wonderful husband. You just try to understand as much as you can. I look at it with a different perspective because it is something from my own life." These personal experiences in some way sensitized the nurses in their ability to connect and be present.

The three distinct transitional influences of integrating technology, maturing as a critical care nurse and life experiences all contributed to the evolution of these nurses' presence in practice. In coming to know the whole of their evolving presence, the nurses described their understandings of presence in nursing practice as part of who they were as people, not only as nurses. In this aspect the nurses were coming to know presence as a practice, an evolutionary process.

Professional Influences

In describing professional influences, the participants identified the interplay of colleagues, the professional environment and reflection in their ability to practice presence.

Mentors and Colleagues "So much More"

Mentors were described as professional colleagues whom the new nurses respected and emulated. In developing ongoing relationships with mentors, the participants observed role modeling of presence in practice. The participants highlighted those expert nurses who were particularly good at relating with patients and families in their descriptions. One nurse describes this influence: "It's something you observe and it doesn't seem important at the time... but when you see it, it instills a lot of respect... Her patients respect her very much... She has all those clinical skills going on. She has all of those things and so much more."

Often the nurses indicated they learned patient interaction skills as well as presence by example in observing expert nurses engaging with patients and families. One participant described how she had no idea how to talk to an unconscious, intubated, sedated patient, that she was embarrassed to do this but learned how to by observing others around her. Another participant described the influence of her mentor as having a positive impact on her confidence to interact with patients and families. The influence of others was described as a combination of both rich mentoring experiences or more momentary observations of presence in practice. The nurses often identified that learning from examples in practice was a significant way in which they learned to nurse in the ICU. They were able to observe presence in practice and learn from these influences. The

mentoring influence was not only in observations of practice, however, mentors were described as conveying a strong valuing of caring connection as an important aspect of clinical competence and the professional role.

Practice Reflection "That's a good way to do it"

The participants in the study acknowledged that their development of presence in practice progressed as a result of internal reflections as well as external influences. Making mistakes and learning from them was described as part of the process, not just in relation to technical clinical skills, but also skills in relating and being with patients in a connected way- being present. "Sometimes we do things and we think…'why did I do that?… That was really the wrong thing'. Every patient reacts differently to you. One guy you can horse around with … the next guy, you need to call him Mr… You see how the patient reacts and you think… that's a good way to do it."

One nurse described how she now listens to shift report on her patient "with a grain of salt" learning from prior experiences that sometimes reports could influence her to have pre-conceived misconceptions about her patient, which was something she wanted to avoid.

Part of the self reflective nature of developing an enhanced ability for presencing was in the recognition by the nurses that influences on their practice were ongoing and that their practice would always be evolving. For example, one seasoned nurse described recently gaining new insights from a continuing education session on spiritual and cultural care, another identified the meaning she experienced in her work as a member of the professional team in the ICU, while caring for a patient that truly valued the person's uniqueness.

Discussion

The main findings for this study were that, as an evolutionary process, presence can be learned. How nurses do this was subject to a process over time, as well as various influences: a) novice nurses in the ICU environment need to develop technological competence before evolving in their ability for nurse presence; b) personal life experiences influence the development of presence; c) presence can be observed in others and as a result, nurses often learn presence from mentors; and d) practice reflection contributes to the development of presence.

Integrating technology rather than being overwhelmed by it occurred within the first year of practice for the nurses in this study. The two step transition from being overwhelmed by technology to seeing beyond, it allowed the nurses to move forward in their ability to connect with the patients and families for whom they were caring. As an evolutionary process, the development of nurse presence in practice for the nurses in this study was gradual and iterative. In other words, each influential experience built on the last and had a cumulative effect, bringing these nurses toward a richer knowing of presence in their practice. An important component of this cumulative effect was the recognition by the participants that their own life experiences had an influence in their development of presence in their professional work. Transitional influences on presence emerged as a combination of both professional and personal transitional experiences.

Collegial relationships as well as more richly developed mentoring relationships played a significant role in influencing the participants as they developed towards an enhanced ability to presence in their practice. Simply observing present, expert practitioners interacting with patient and families, in the practice environment provided

important learning of presence for the nurses. The influence of others along with practice reflection and a supportive team environment added to the evolutionary process of developing presence in nursing practice. In their descriptions of the influences of others, the participants in this study shared that both mentoring relationships, with an influential valuing of the aesthetics of nursing practice, and role modeling of presencing behaviours influenced them in the development presence. This finding is significant in suggesting that presencing behaviours can be observed and learned, and is congruent with the earlier part of these research findings that demonstrated nursing presence was a three staged process of commitment, presencing strategies and connection (Hain, 2007), illustrated in Figure 4.2. Presencing strategies in these earlier findings emerged as attributes of presence and represent tangible ways of being or ways of doing .

The development of presence for the participants in this study also included a component of practice reflection. The importance of reflection has long been recognized as a valuable contributor to enhanced practice, offering a vehicle for finding personal meaning in experiences , and therefore richer understandings. (Hesook, 1999; Peden-McAlpine et al, 2005; Russell, 2005). Johns (1995) points out that "the essential nature of learning through experience is reflexivity" (p. 226). He goes on to comment that learning to become an effective practitioner is not simply a question of skill acquisition. Russell (2005) argues that reflective practice need not be 'fluff' and that if mentored well in the art of reflection, professionals can grow in their practice" (p. 45). As described from the data, an element of practice reflection was evident in these nurses' experiences of learning to presence.

Godkin (2001), expanding on Doona, Haggery and Chase's (1999) research on nurse presence, integrated a novice to expert model theorizing that presence as a practice can be developed. Producing a model using Benner's (1984) idea of novice to expert practice, Godkin theorized that novice nurses, while maintaining bedside presence, do not achieve the same level of intensity of presence as their expert peers. According to Godkin, with experience and "nurse task maturity" nurses move through a "zone of transition" toward a richer, higher level of presence described in the model as healing presence. These hypotheses of how nurses develop healing presence are supported by the findings of this study, in that knowing a richer, deeper (or healing, according to Godkin) level of presence takes time and comes more readily with maturity and clinical experience. In sharing their experiences of learning connectedness with their patients, the nurses in this inquiry described a common thread of coming to know the whole, knowing the holistic nature of their work beyond the technological imperative to efficiently save lives (Benner, Hooper-Kyriakidis & Stannard, 1999). They came to a richer understanding of how to presence and that their presence comprised an important and vital part of holistic nursing practice in the ICU.

Implications for Practice

A healthy and important debate still continues in efforts to understand presence as an elusive but known element of caring practice. The findings of this study suggest that ability to presence in nursing practice is learned and therefore, our understanding of this process can be incorporated into creative, holistic, clinically-based learning programs.

Based on the results of this study, experiences of presence in practice and personal reflections on connection, as well as the recognition of the importance of

mentors and access to expert clinical modeling should be incorporated into clinical learning for new nurses attempting to integrate skilled technological competence with humanistic, compassionate caring (Table 4.1). An example of a strategy for education of presence is evidenced in a two day course run by McKivergin and Daubenmire (1994) . These facilitators use prompts in order to stimulate self-reflection on presence in practice, such as: What are the experiences of presence in my life?, What does it mean to be fully present to another? How can I become more aware of opportunities to be present to others?

Mentoring and role modeling are essential components to supporting the newer nurse learning, not only technological skills, but intuitive and aesthetic knowing such as attuning to subtle cues and being present for patients and families (Kanaskie, 2006; McKinley, 2004; Pyles & Stern, 1983). Learning presence, facilitated by mentors and reflective practice is possible and should be incorporated into basic and continuing critical care nursing education. Without integration into education programs, ontological understandings of presence in critical care nursing may stay in the realm of the personal, private world of the nurse's experience and may never be fully realized and validated as a vital component of skilled, compassionate nursing care.

The critical care nurse's evolving presence is developed through experiences and influences with each experience informing the next, bringing the beginning practitioner closer to fully knowing how to presence. Nurse presence as a practice is informed by the evolutionary nature of developing presence. Nurses come to know their patients, the humanity of their practice as well as how to presence in this holistic way. Figure 4.2 illustrates the integration of the development and practice of nurse presence.

Conclusion

Nurse presence is learned by nurses coming into high technology ICUs. Nurses can and do evolve in their knowing of presence and share this knowing with each other. This study demonstrates that support by expert mentors and guided practice reflection can lead to a richer knowing of nurse presence for novice critical care nurses. Professional development programs, orientation programs as well as basic critical care programs should incorporate nursing presence as an essential component of curricula.

Nurses bring themselves to the aesthetic art of their practice; they share of themselves with those entrusted in their care.

Figure 4.1

Evolving nurse presence: Coming to know the whole

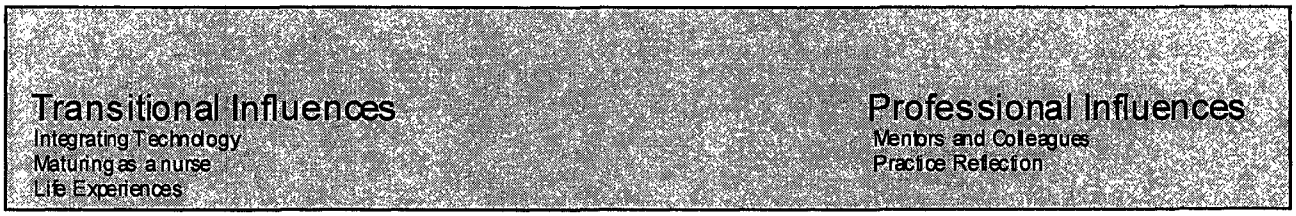

Figure 4.2

Evolving nurse presence: Development and Practice

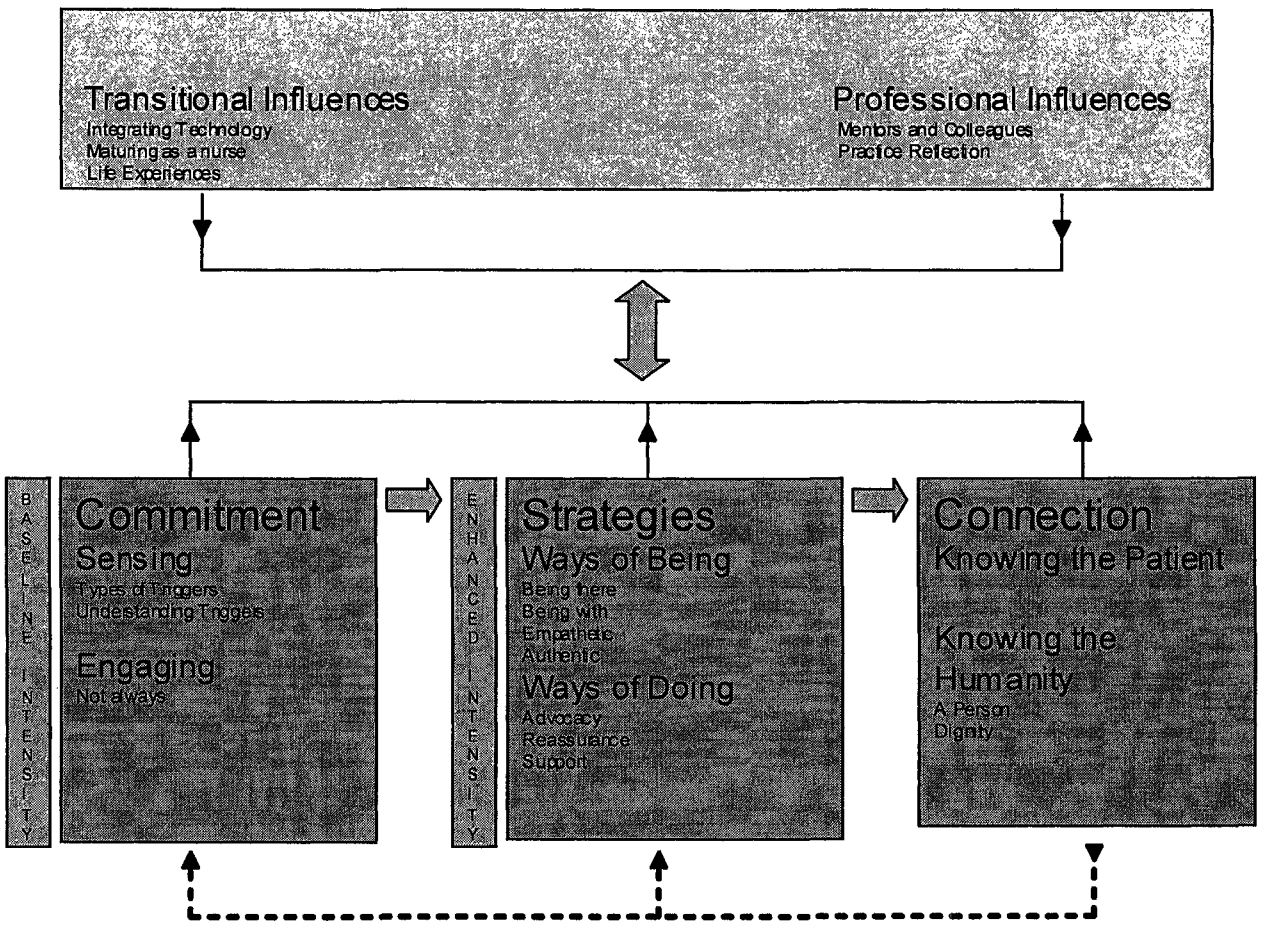

Table 4.1

Learning Presence in Nursing Practice

Integration of presence in Nursing Practice
Standards of nursing practice that incorporate presence
Patient and family testimonials of the experience of being cared for in the Intensive Care Unit provided to the unit staff in continuing education sessions
Mentors sought for technical expertise as well as presencing ability
Understandings of presence in practice included in unit orientation
Spiritual and cultural care strengthened through education
Practice reflection integrated into education sessions, placing equal value on technological competence as well as relational competence
Expert nurse testimonials of how personal experiences influenced their ability to be present

Chapter 5

Conclusion

How expert professional nurses practice and develop nurse presence in a critical care unit: A grounded theory study

"Trying to get to know your patient is at the root of making a difference."

Introduction

The intent of this research was to increase an understanding of the nurse's presence in clinical nursing practice within the critical care setting. This chapter will expand upon the research methods and the ethical approval process for this study, as well as integrate the findings of the two part research question, how do expert professional nurses practice and develop nurse presence in a critical care unit? Additional discussion of the implications to practice, education and research along with the limitations of the study will conclude this thesis.

Methods: Expanded Discussion

Design

This project used qualitative, grounded theory (GT) methods as described by Strauss and Corbin (1998). This qualitative method of inquiry has a theoretical base of symbolic interactionism which suggests people order their world based on meaning in situations, in particular shared meaning (Benzies & Allen, 2001; Morse, 1992). This sociological research method assumes that reality is not constant and that meanings change and are modified. The assumption that GT (Strauss & Corbin, 1998) allows for "a description of steps or stages" (p. 21) and that meaning for a person may change as they gain experience validates the GT method as a good fit for this particular project.

The grounded theorist is looking for dimensionality, variation and relationships among concepts (Holloway & Wheeler, 2002). Unlike phenomenological research methods, which yield rich understandings of concepts, grounded theory illuminates processes and relationships between concepts, offering a predictive component to qualitative research, which is realized in the development of a conceptual ordering or a

theory (Strauss & Corbin, 1998). It is not expected that every GT research study produces a theory of the phenomenon in question. Strauss and Corbin (1998) describe a pre-theoretical conceptual ordering that orders data according to steps or stages. The purpose of developing a conceptual ordering of the central process of the practice and development of nurse presence was achieved in this study.

The GT method leads the researcher to use the techniques of induction, deduction and confirmation (Strauss & Corbin, 1997). The investigator starts data analysis concurrently with data collection. As cues, concepts and themes emerge; deductions are made which focus the data collection toward an affirmation of the induction/deduction process. Sampling and data collection become more and more focused as analysis gives direction to conceptual ordering and theory development (Holloway & Wheeler, 2002).

Setting and sample

The setting and sample for this study have been described in Chapters three and four. A homogeneous sample was obtained in order to gain a concentrated access to the phenomenon of nurse presence. Holloway and Wheeler (2002) describe a homogeneous sample as "... involving individuals who belong to the same subculture or have similar characteristics" (p.123). The initial invitation to participate in this study was made to participants by the unit educators or a participant colleague. A snowball method of sampling was used once access was gained to the initial participants. Chain referral or snowball sampling is described by Morse (1993) as nominated sampling. In other words, participants already recruited into the study nominate potential participants who meet inclusion criteria. Usher and Monkley (2001) used the snowball method to increase recruitment of expert ICU nurses to their study on effective communication in an ICU

setting. The snowball method of recruitment offered increased access to potential participants. According to Strauss and Corbin (1998) saturation of a category is determined when "no new information seems to emerge during coding, when no new properties, dimensions, conditions, actions/interactions or consequences are seen in the data." (p.136). The sample size of nine nurses was determined as categories were saturated during the iterative process of data analysis, which started with the first interview according to the grounded theory method. Repetition of ideas became evident in the participant interviews. Saturation was determined when no new variables or dimensions of the three main and six sub-categories emerged, in other words no new questions were generated and no new experiences emerged (Morse, 2003). The process of recruitment occurred over a nine month period.

The potential participants were given a letter of invitation outlined in Appendix G. Once the participants expressed an interest in participating in the study; they were contacted by phone to choose a time and place that was convenient for the interview. After an explanation of the study, an informed consent outlined in Appendix H was obtained by the researcher prior to the beginning of the semi-structured interview. All nurse participants were provided with a copy of the written informed consent under the principles of full disclosure (Penrod, 2003).

Data Collection

The primary data collection technique was individual semi-structured interviews, 45 to 90 minutes in length at either the hospital or in the participants' homes at their convenience. Each participant was interviewed once and later received a mailed copy of the abstracts and diagrams from the findings followed by one telephone call to confirm

concepts. The interview consisted of open-ended questions, with additional prompting to elicit more detail (Appendix I). Following GT methods, as the study progressed, prompting became more focused based on prior interviews and emerging findings. A greater understanding of the barriers to presence in clinical nursing practice was achieved by adding an additional question regarding this dimension to the interview tool and with focused prompting in the final interviews. Demographic data collection, Table 3.1, was completed during the consent and interview process. With the participants consent, the interview were tape-recorded and transcribed to written copy at a later date.

The term connection as well as nurse presence was used to communicate with the participants about the phenomenon of nurse presence, as the linguistic term nurse presence is a created construct that may have no literal meaning to some clinical nurses. A broad open-ended question was used to open the interview by focusing the participant on their experience of nurse presence. The participants were not interrupted as they described their experience.

Data Analysis

In the grounded theory method, data analysis goes on throughout the research (Strauss & Corbin, 1998). Coding in grounded theory is the process that is used to identify concepts or themes. Data from the participants is transformed, using a constant comparative technique, to build categories and through an emergence of these categories theory can be evolved (Holloway & Wheeler, 2002).

Data coding process. Analysis included three levels of coding- open, axial and selective coding with the aid of Ethnograph © a computer software package designed for qualitative data management. Transcribed interviews were imported into this data

management program which contributed to a systematic reduction of data through a coding process. Level 1 or open, Level 2 or axial and Level 3 or selective coding is used in GT to reduce the data and make sense of it. Open coding (Level 1) is the first step where relatively simple codes are used to catch the essence of the phrase. Sometimes these codes are named for words used by the participants; Strauss refers to these codes as in vivo (Strauss & Corbin, 1998). An example for this inquiry is the word "relate". Axial codes are then formed by grouping like concepts from open codes (Level 1) together into major categories, which although grounded in the data are also formulated by the analyst going back to the academic literature. The axial, level 2 categories tend to be more abstract. An example of an axial level coding from this study would be "strategies". The main features or properties of these axial, level 2 categories are identified at this phase of the data reduction process, an example from this study would be the inclusion of empathy as a property of the main category "strategies" (Holloway & Wheeler, 2002). Selective coding signifies the development of relationships between major categories; these major categories contain developing theoretical ideas. Taking the major categories and relating them down to sub-categories is called axial coding, while relating the major categories between each other is called selective coding (Strauss & Corbin, 1998). A core category or basic social process (BSP) should emerge in grounded theory technique. Holloway and Wheeler, 2002 describe this category as "a thread that should be woven through the whole study and provide a story line" (p. 160). Coming to know the whole emerged as the BSP for this study. During the coding process emerging ideas are taken back to the data collection in a process of testing of these ideas. One example of this constant comparative technique would be having the researcher describe the meaning provided by

this method is multidimensional in that the process builds knowledge from participants' meaning; but also incorporates concepts from the literature (Holloway & Wheeler, 2002). As this study progressed, new probes were added to the interview tool regarding the absence of presence, in accordance with the GT method, in order to illuminate the dimensionality of developing categories.

Rigour

At the point data reduction reached levels 2 (axial) and 3 (selective) coding, where major categories/themes were being developed and inter-related, the research committee members met to discuss and further clarify inconsistencies in the analysis. The research process was also aided by the close involvement of a primary supervisor, expert in GT methods. External auditing was used to determine the stability of the data analysis in the form of a member check or mailing of major categories/themes to the participants for feedback during a telephone contact (Appendix J). The participants confirmed that the proposed major categories and the process of practicing and developing nurse presence resonated with their experience. Due to a geographical move from the city, one participant was unreachable for the feedback process.

Credibility. Credibility attempts to demonstrate the truth of the findings (Holloway & Wheeler, 2002). This was achieved by conducting interviews that were long enough to allow the participant to voice his or her experience and meaning. Open ended questions with probes were used to achieve thick data that was rich in the dimensions as well as variablity of the experience. Participant or member checks, in the form of a mail out of findings and telephone follow-ups, also contributed to the credibility.

Confirmability. Consistent with the grounded theory method, (Strauss & Corbin, 1998) an audit trail in the form of memos was produced by the investigator during the project, lending the analytic process an element of transparency. Developing ideas were represented by diagrams that were dated and frequently modified as the understandings of nurse presence in the ICU became clearer.

Dependability. For qualitative research the criterion of dependability is to evaluate data quality (Polit & Beck, 2004). For this project, premature closure was avoided by ensuring a saturation of the codes and categories. This was evident when no knew questions arose. Initial interview transcripts were examined by a primary supervisor for quality of interview technique and richness of data.

Transferability. This criterion of rigor is comparable to the qualitative form of external validity found in quantitative research (Poliot & Beck, 2004). This study focused on the ICU nurses perspective, however the examination of the novice to expert dimension of the developmental of presence, by asking experts about their novice experiences, lends an aspect of transferability to another context.

Protection of human rights

Approval for the use of human subjects was obtained in June 2005 through the research ethics board (Appendix F). The appropriate administrative approvals were also obtained from the nursing leadership at the hospital. The director of critical care, the nurse educators as well as the manager of the ICU offered support of this project (Appendix E).

Participants were informed that they could choose not to participate, withdraw or stop an interview without any consequence to their employment. Original tape recordings

and full transcripts were stored in a locked drawer and will be destroyed two years after the conclusion of the research in accordance with the hospital's research ethics review board procedures. Participant's identity was protected.

Integration of Findings: Practice and Development of Presence

The research objectives:

1) to explore how expert nurses employ nurse presencing in a Critical Care Unit

2) to examine how expert nurses acquire skill in nurse presencing in a Critical Care Unit and

3) to develop a conceptual ordering for the process of nurse presence in a Critical Care Unit, were achieved.

The grounded theory that explains the full process of the practice and the development of presence, is how practice experiences link to a developing knowledge base of presence. Each practice experience is part of a long learning curve, a journey over time, which combines a knowing of the unique patient with a knowing of presence that is richer and deeper. A greater appreciation for the complexity of what may have seemed very simple in early practice is developed as the nurses mature as people as well as in their professional roles. Influences, which include mentors and life experiences, are integrated with practice reflection to bring the nurse closer to fully understanding and embracing presence as a powerful component of their nursing care.

The practice of nurse presence

While this inquiry found that the experiences of presence in clinical practice in the ICU were consistent with findings reported in the literature, new information was discovered that contributes to a greater understanding of this concept. As the conceptual

interrelationships emerged during analysis, a dynamic process of presence was more clearly elucidated in the identification of three phases of presencing : commitment, presencing strategies and connection; a conceptual ordering of these phases was subsequently developed. Much of the previous research conducted in this field has used phenomenological methods, yielding rich descriptions of the components and meanings of presence (Covington, 2005; Gilje, 1992; MacKinnon, et al, 2003) but offering limited understanding on how presence is practiced as a process, this study has illuminated this process.

In this study, at the initial commitment phase of presence with sensing and engagement, the participants demonstrated an increased ability for presencing based on their sensitivity to and understanding of patient and contextual triggers. This suggests that an ability for presence can be developed as clinicians gain confidence and experience in their establishment of presence with patients in the ICU. Consistent with the literature, presence was noted to exist on an interval level of intensity from low to high (Easter, 2000; Osterman & Schwartz-Barcott, 1996). To explain further, in this study, nurses were present to their patients more or less continually as a way of being, on a baseline of intensity. As the patient's need for an enhanced connection was recognized in expert assessments, an enhanced intensity of presence was employed by the nurses engaging deliberately in the moment. Congruent with previous understandings of clinical decision making (Thomas & Fothergill-Bourbonnais, 2005), cue utilization was an important component of these clinical judgments made in the process of presencing.

At the second phase of the process, strategies of presence were accessed as interventions at an enhanced level of presence in response to understanding patient or

contextual cues. Covington (2003) noted in her review of the nurse presence literature that presence emerged as both an attitudinal and behavioural phenomenon, which seems to be consistent with the findings from this study. Intensity of presence was selectively applied based on patient need. For example, presence was described as being conveyed with a quick reassuring touch versus an intense sharing of self energy in being with the other. Nurse presence emerged as an intervention that nurses can access at an enhanced intensity. Paradoxically this enhanced intensity of presence would not be applied without a baseline intensity of presence as a way of being, described by Caldwell et al (2005) as a continual awareness of the irreplaceable personhood of the patient [client]. As a way of being, a baseline intensity of presence in the commitment phase of presence ensured a sensitivity to cues that triggered an awareness of patient need for enhanced presence. In considering the intricacies of the initial phases of the presencing process, the complexity of the nurse's presence emerged along with the finding that presencing involves expertise.

Connection, as the final phase of the presencing process, was comprised of connecting to the patient as a unique person, coming to know the patient or in the broader sense connecting to the humanity of the experience of being critically ill. A reverence for the human being as an essential component of this connection emerged as maintenance of dignity and recognition of the person. Reciprocity as an attribute of presence is noted in the literature (Covington, 2002; Doona et al,1997) but was not always possible in the context of critical illness, as patients were not always capable of reciprocating a connection. This explains why a connection to the basic humanity of the person in the experience became an important component of presence for ICU nurses.

The development of nurse presence

The aesthetic knowing of nurse presence in this study was comprised of intuitive awareness, perception, and expertise. Aesthetic knowing first described by Carper (1978) includes understanding alternate modes of reality and a comprehension of the whole. This aspect of aesthetic knowing and comprehension of the whole was found in this study in the participants' descriptions of seeing beyond the technology of the ICU to the patient's whole person and experience. The findings revealed that nurse presence as a practice was continually evolving towards an expert knowing. Transitional influences in the development of presence combined to enrich the personal and aesthetic knowing of nurse presence in practice.

The critical care nurse's evolving presence is developed through experiences and influences, each experience informing the next, bringing the beginning practitioner closer to fully knowing how to presence. Nurse presence as a practice is informed by the evolutionary nature of developing presence. Nurses come to know their patients, the humanity of their practice as well as their presence in this holistic way.

Implications for practice

Presence in practice provides meaning for nurses in their work. As critical care areas become more complex, with rapidly changing technology and shifting patient and staff demographics, pressures placed on nurses may lead to a de-valuing of caring practices such as presence. In connecting with the humanity of the experience of critical illness in the process of presence, nurses acknowledge their own humanity as well as their patient's; disconnection from humanity has the potential to lead to objectification of patients as well as nurses. Numerous studies tell us that patients and families value the

nurse's presence as a crucial component of their comfort and healing (Attree, 2001; Covington, 2002; Davis, 2005; Gramling, 2004; Gilje, 1992; MacKinnon et al , 2003). Nurse presence, then, emerges as a basic component of quality patient care.

Early problem recognition (Minik, 1995) as a component of the patient safety movement (Dodek, 2005; Valentin, et al, 2006) is also linked to presence in nursing practice, with the attributes of focused attention and recognition of subtle cues. It is essential that organizational decision making in tertiary care centers support a culture of presence in practice. Support for a caring culture that values the nurse's presence takes more than mission statements. Policies and budget decisions impact the realities of valuing the human connection in complex, dynamic and often budget restrained health care systems. A culture of presence can be realized with appropriate nurse-patient staffing ratios, an even balance of part-time and full time staff to achieve patient continuity and professional development, as well as tangible support for clinical nurse mentors who contribute a great deal to newer nurses learning the aesthetic art of nursing.

Implications for education

An important contribution of this study emerged from an understanding that nurse presence can be learned in the clinical environment. Nurses can observe presence in practice and learn from these observations. Also, nurses are supported by mentors who role model and nurture the development of values that place an equal relevance to the aesthetic art of nursing as well as technical competence. Certainly nurses need technical, empirical knowledge to compliment their skills in presencing. Being present and offering presence as an intervention for professional nurses is a component of skilled nursing that relies on recognition of subtle and complex patient cues as well as an ability to delineate

physiologic responses to illness from emotional ones. Presence is also about timing-being there just as one is needed. As nurses build upon their empirical knowledge and skill, they build upon their knowledge of how to presence with patients. In this light, nurse presence is delineated from lay presence.

Nursing education needs to incorporate the concept of presence into curricula. Often, an emphasis on empirical and ethical knowledge (Carper, 1978) relegates aesthetic and personal knowledge to trial and error in the clinical area. Nurse presence as an aesthetic art can be developed by critical care nurses and should be added to basic critical care programs, orientation programs and continuing education. Components of the patient's experience should be added to every academic exercise, placing an equal emphasis on empirical, ethical as well as aesthetic and personal knowing (Table 4.1). Currently, serious shortages of critical care nurses coupled with demographic pressures for increased access to critical care treatment mean there is a steep increase in the number of novice ICU nurses in the critical care areas (AACN, 2006; Murray, 2002). These novice nurses need educational support and mentoring to ensure not only technological competence, but also a valuing and development of caring practices.

Implications for further research

The conceptual ordering of the phases of nurse presence developed from the findings in this study offer increased clarity to how presence is realized in the clinical arena. As well, the understanding of how nurses develop their ability to presence, adds to the knowledge of this concept. Questions for the discipline of nursing regarding presence in practice emerge:

Development of understanding, outcome measures:

1. What is the ICU patient's experience of nurse presence?
2. What are the patient and family outcomes of the nurse's presence in the ICU?
3. What are the outcomes to an absence of presence in practice?

Not much is understood about a practice environment that might support presence in practice. One must consider the impact job dissatisfaction, potentially evidenced by high turnover rates and minimal professional development incentives could have on professional nurses in their commitment to their workplace and ultimately connections with their patients.

4. What are the environmental and cultural contributors to expert presencing in practice?
5. How do nurses overcome barriers to presence in practice?
6. Does the experience of connectedness with patients contribute to retention of critical care nurses?

Understanding that presence is learned by nurses:

7. What teaching methods contribute to learning presence in practice?
8. Can an educational program teaching nurse presence impact practice?
9. What are the preferred methods of learning presence in practice?

Limitations

The study has limitations in that it was an intensive examination of nurse presence within one institution with a homogenous group. Studies in other institutions may yield different results because of the differences in staff education and organizational culture. Organizational and unit culture could clearly have an impact on professional nursing

practices, studying the unit culture for this study was beyond the scope of the objectives of this research, but may act as a limitation. Also, interviewing experts on their recollections of their early practice may have been influenced by the passage of time (Sandelowski, 1991).

Conclusion

In this grounded theory study, nine expert critical care nurses shared their experiences of presence with seriously ill patients and their family members in an ICU. Presence emerged as a dynamic process comprising three phases- commitment, presencing strategies and connection. An enhanced presence and ultimately a human connection resulted from expert sensing and a willingness to engage in the moment. Presence was realized in ways of being – being there, being with, empathetic, authentic and ways of doing – advocacy, reassurance, support. Presencing in this context emerged as a powerful and essential humanizing element of nursing the critically ill.

The main findings for developmental component of this study were: a) novice nurses in the ICU environment need to develop technological competence before evolving in their ability for nurse presence; b) personal life experiences influence the development of presence; c) presence can be observed in others and as a result, nurses often learn presence from mentors; and e) practice reflection contributes to the development of presence.

Nurse presence is learned by nurses coming into high technology ICU's. Professional development programs, orientation programs as well as basic critical care programs should incorporate nursing presence as an essential element of content.

As Younger (1995) stated, "The most demanding and deeply human aspect of caring is the expressive art of being fully present to another person" (p. 67). Despite remaining private and unrecognized, as many experiences of presence in clinical nursing practice may still be, nurses know and value the art of being a presence, in truly connecting with their own humanity and the humanity of those they care for.

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Appendix A
Authorship Credit

Authorship Credit

This thesis was manuscript based and as such is comprised of chapters that were intended for publication in a peer-reviewed journal. Chapter 3 will be submitted to 'The Journal of Holistic Nursing'. Chapter 4 will be submitted for publication in a critical care nursing journal that has yet to be chosen.

Contribution of Collaborators

The two manuscripts were produced from one study with a two part research question. The principle author of the two manuscripts was Abigail Hain (AH). As a partial fulfillment of the requirements for a graduate degree in Nursing, AH was responsible for the design of the study, data collection, analysis and writing of the manuscript. As thesis supervisor, Dr Jo Logan (JL) also participated in the formation of the design, provided critical feedback on coding of the data, as well as throughout the analytical process. JL also extensively reviewed the drafts and edited the final manuscript.

Dr. Betty Cragg (BC) and Riek van den Berg (RV), as members of the research committee, provided feed back during the analytical process and the subsequent development of the conceptual framework. As an expert in grounded theory methods BC contributed valuable critique to coding procedures and category development. As an expert in the field of critical care nursing RV provided valuable critique of the developing conceptual framework. BC and RV provided feedback at research committee meetings and in revision of the manuscripts. The order of authorship was determined by consensus of the thesis committee members and graduate student.

Appendix B
Construct Development Literature Tables

Table 2.2

Construct Development

Author Article Citation Key Words	*Concept Type of Article Country*	*Key Arguments Key Themes Evolving Definitions*
Carpenito, L (2000) Nurses, always there for you. Nursing Forum. 35 (2) 3-5	Presence Discussion USA	• Difference between being there and "just" being there • Presence as a powerful nursing intervention • Avoid patriarchal role relationships "When we try to provide the solution for others, we negate their individuality and their personal experience" (p .3)
Chase, S. (2001) Response to "the concept of nursing presence: State of the Science" Scholarly Inquiry for Nursing Practice: An International Journal 15(4) 323-327	Presence Response/ Construct Development USA	• Presence not accessible to positivist methods of inquiry • Presence not a cause and effect concept • Essential feature- reciprocal experience for nurse and pt • Occurs through interaction (versus technique) • Variable characteristics of the concept acknowledged • Time not of essence but nurse ability to focus with intent is
Covington H. (2003). Caring Presence. Journal of Holistic Nursing. 21 (3), 301-317	Caring Presence Concept Analysis USA	• Caring presence is a way of being that allows for the nurse and patient to connect in a human-human experience that promotes healing • Presented as a way of being, a way of relating, a way of being there and being with, as a nursing intervention • Outcomes: sharing vulnerability and suffering, transformation and growth, transcendence, healing, exchange of energy
Donna, M., Haggerty, L, & Chase, S. (1997) Nursing Presence: An Existential Exploration of the concept. 11(7) 3-16	Presence Construct Analysis and Development USA	• Dissent entered scholarly discussion – Critique of Gardner's "utilitarian" definitions of nurse presence • Presence argued as a philosophy and not an intervention, cannot therefore be reduced to techniques – "choice the nurse makes as a way of being" (p. 8) • Argue that the definition of the concept is being weakened • Cannot teach presence, can nurture it
Easter, A. (2000) Construct Analysis of four modes of being present" Journal of Holistic Nursing 18 (4), 362-377	Presence Construct Analysis and Development, Case study- Exemplars Model Development USA	• Physical Presence: Body-Body, Being there, touch, doing, skills, knowledge • Therapeutic Presence: Mind-Mind, Support, comfort, hope, coping enhanced • Holistic Presence: Body-Mind- Spirit, conceptual framework- Rogers Unitary Man, Simultaneous Action worldview, connection, therapeutic touch • Spiritual Presence: Spirit-Spirit, Transformative for the nurse and the patient, transcendent awareness that is higher than cognitive thinking, communion- no words, no roles, conceptual model – Parse's Human Becoming Theory • Nurses choose mode based on their assessment- years to develop skill
Fredriksson, L. (1999) Modes of relating in a caring conversation: A research synthesis on presence, touch and listening. Journal of Advanced Nursing 30 (5) 1167-1176	Presence, touch and Listening Research Synthesis Model Development Sweden	• Being there (attentive attitude) Being with (whole persons, more than roles) • 10 articles on presence synthesized • Tentative model produced Patient A- wants a connection, Patient B- wants contact • Assumption- human beings are free to choose the way they want to relate • Model of connecting versus connection

Author *Article Citation* *Key Words*	*Concept* *Type of Article* *Country*	*Key Arguments* *Key Themes* *Evolving Definitions*
Gardner, D. In G. Bulechek and J. McCloskey (Eds.) Nursing Interventions: Treatments for Nursing Diagnosis (1992) (pp. 316-324) Philadelphia, Saunders.	Presence Text Book Chapter Case Study-Exemplars USA	• Cognitive, affective and physical domains of nurse presence described • Presence may be incorporated into care • Presence may be the intervention of choice • Presence as a sub-construct of Caring • Applied aspects discussed
Gilje, F. In D. Gaut (Ed) The Presence of Caring in Nursing (1992) New York: NLN	Presence Nursing Text Book Chapter USA	• Physical, Psychological, Emotional and Spiritual realms of concept • Absence of presence- objectification and degradation of patients • Key element: reflective state of consciousness (nurse) – Assumption • Appreciation for humanity (existentialist roots)
Godkin, J. (2001) Healing Presence. Journal of Holistic Nursing. 19 (1), 5-21	Healing Presence Model development USA	• Using Donna et al (1999) model combined with Benner' s (1984) idea of novice – expert, theorized a hierarchical development of presence over time in relation to experience and expertise in nursing practice
Marsden, C. (1990) Real Presence Heart and Lung 19 (5) 540-541	Presence Ethical Issue/Discussion USA	• Present to self (nurse) to be present to another • Sensitive to different beliefs and values (culture) • Common humanity • Humanize technology (critical care) • Avoid patriarchal role relations- no hierarchy, no judgments, respect
McKivergin, M. & Daubenmire, J. (1994) The healing process of presence. Journal of Holistic Nursing. 12 (1) 65-81	Presence Application/course description USA	• Hospice nursing environment • Recognize levels of presence – physical, psychological, therapeutic • Course description of the essence of presence in practice • Present to self first in order to be present to others • Incorporate therapeutic presence into the standards of care for hospice
McKivergin, M. (1998) Presence: Creating order out of chaos. Seminars in peri-operative nursing. 7 (2) 96-100	Presence Application USA	• Peri-operative experience • Antecedent to nursing presence- patient uncertain- chaotic system
Melenechenko, K. (2003) To make a difference: Nursing Presence. Nursing Forum 38 (2) 18-24	Presence Literature Review/theory to practice USA	• Negate patriarchal relations between patient and nurse • Recognize the privilege • Scholars are identified as Cartesian in their definitions of presence, subject-object relations • Parse practice methodology described as a framework that recognizes "true Presence" and Is not Cartesian
Snyder, M., Brandt, C. & Tseng, Y. (2000) Use of presence in the critical care unit. Clinical Issues in Advanced Practice and Acute Critical Care 11 (1) 27-33	Presence Practice Application/Research Synthesis USA	• ICU dehumanizing place- presence a humanizing concept appropriate and needed for ICU • Exemplars of Osterman's modes of presence given for the ICU setting • Early problem identification recognized as an outcome of presence • Key components – whole person to whole person, intersubjective, attentiveness, accountable • Skills to practice presence- centering, sensitivity and openness, communicating and listening • Attempt to operationalize the concept in a specialty context

Author *Article Citation* *Key Words*	*Concept* *Type of Article* *Country*	*Key Arguments* *Key Themes* *Evolving Definitions*
Smith, D. (2001) The concept of Nursing Presence: State of the Science. Scholarly Inquiry for Nursing Practice: An International Journal, 15 (4) 299-322	Presence Construct Analysis/Development USA	• Important to develop conceptualization as well as application of concept • Outlined 2 arguments in the scholarship: 1. Philosophy or intervention, 2. Can presence be taught? • Chronological development of the concept- philosophy/religious, intuition, intervention, dissent, field research • Ethical question of inherent "gift" for presence • Presence – complex and problematic • Is presence always desirable or even possible?
Stanley, K. (2002) The healing power of presence: Respite from the fear of abandonment. Oncology Nursing Forum. 29 (6) 395-340	Presence Discussion USA	• Oncology nursing context • Abandonment and loneliness in illness (suffering) • Mode of being, Connection, Affirmation and valuing, Knowing the other • Acknowledges vulnerability, Requires intuition, to be vulnerable, Serenity and Silence • Transcendent (can be)
Vaillot, M. (1966) Existentialism: A Philosophy of commitment. American Journal of Nursing 66 (3) 500-505	Commitment Existentialist Philosophy Nursing Philosophy Development USA	• More to nursing than the medical model • Bestowing services versus sharing the human experience • Nursing technique versus giving of oneself • Both nurse and patient grow in their becoming based on the experiences shared • Commitment
Younger, J. (1995) The alienation of the sufferer. Advances in Nursing Science, 17 (4) 53-72	Suffering Construct Analysis USA	• Music, art and myth are refracted experiences of presence • "Most demanding and deeply human aspect of caring is the expressive art of being fully present to another person" (p.67) • "To be present means to unconceal, to be aware of tone of voice, eye contact, affect and body language, to be in tune with the patient's messages" (p.67) • Link between the sufferer and the need for presence • Silence may be filled with communicative meaning

Appendix C
Related Concepts Literature Review Tables

Table 2.3

Related Concepts

Author *Article*	*Method* *Sample* *Country*	*Purpose of Study* *Description of Presence*	*Results* *Comments*
Attree, M. (2001) Patients' and relatives' experiences of good and not so good quality care. Journal of Advanced Nursing 33 (4) 456-466 Caring, interpersonal style Patients	Qualitative Grounded Theory Semi-structured interview N=34 patients, 7 relatives England	The aim of the study was to explore patients' and relatives' perceptions of the attributes of care quality and to identify key criteria used to evaluate their perceptions of quality care. Presence: Interactional and interpersonal aspect of caring – central issues in care quality Good care- individualized, humanistic, presence of a caring relationship. Development of a bond or rapport.	Good Care= patient outcome-trust and confidence Negative cases: No respect for patients' humanity, dignity, individual rights and privacy. Distant Not being related to as people
Cronin, S. & Harrison, B. (1988) Importance of nurse caring behaviours after myocardial infarction. Heart and Lung 17 (4) 374-380 Caring Behaviours Patients	Qualitative Unstructured interview Tool: Caring Behaviours Assessment N=22 patients USA	To identify nursing behaviours perceived as indicators of caring by patients who have had a myocardial infarction. Presence patient "make me feel someone is there if I need them" (second most important caring behaviour)	For patients: nursing actions that focused o physical care and monitoring were seen as most indicative of caring. Patients placed less emphasis on qualitative, affective aspects of care
Dyson, J. (1996) Nurses' conceptualizations of caring attitudes and behaviours. Journal of Advanced Nursing Science. 23 (6) 1263-1269 Caring Behaviours Nurses	Qualitative Repertory grid technique N=9 nurses working in a range of settings with a range of experience England	To elicit nurses' conceptualizations of caring attitudes and caring behaviours. Presence: "Giving of self" open, loving, non-judgmental, personal, respects persons, listens, treats patients as people	Themes: Giving of self Consideration and sensitivity Honesty and Sincerity General approach
Fareed, A. (1996) the experience of reassurance: patients' perspectives. Journal of Advanced Nursing. 23 (2) 272-279 Reassuarance Patients	Qualitative Phenomenological N=8 Med/surg inpatients England	To identify which nursing interventions were found to be reassuring to patients. Affect of reassurance on patient outcomes and how to measure. Presence The patients felt reassured when they sensed that the nurse was just there for them. The nurse did not have to be physically with the patient, only accessible or available- convey security. "The nurses were always there when you want them" "to be in tune with the person who needs assurance"	Being with and Being there identified as themes in nurse behaviours that conveyed a sense of reassurance for the patients.
Jenny, J. & Logan, J. (1992) Knowing the patient: one aspect of clinical knowledge. Image: The Journal of Nursing Scholarship, 24 (4) 443-457 Knowing the patient Critical Care Nurses	Qualitative Interview N= 10 Critical care unit Canada	Presence: Presencing was recognized as a nursing intervention. Intuitive empathic knowledge was also recognized.	Experts acknowledged the patient's uniqueness and in doing so were able to wean patients from long term ventilation much more effectively.

Author *Article*	*Method* *Sample* *Country*	*Purpose of Study* *Description of Presence*	*Results* *Comments*
Kapborg, I. & Bertero, C. (2003) The phenomena of caring from the student nurse perspective: a qualitative content analysis. International Nursing Review 50 183-192 Caring Student Nurses	Qualitative Content analysis/written essays N=127 Sweden	To identify and describe the nature of the concept of caring from the novice student nurse perspective. Presence : "Doing" physically present without being mentally or emotionally involved, technical no empathy. "Being" the nurse is mentally present. Could be seen as connecting to patients by listening to their thoughts and fears and communicating concern. Two dimensions "being there" and "being with"	Being there: Nurse show concern for the patients comfort and an understanding of their needs- facilitate meaning. Being with: Available as a fellow being, sensitivity, imagine how it is in another's situation
Minick. P. (1995) The power of human caring: Early recognition of patient problems. Scholarly Inquiry for Nursing Practice: An International Journal 9 (4) 303-321 Intuitive Nursing Critical Care Nurses	Qualitative Hermeneutics Interview Convenience sample N=30 Critical Care Nurses USA	To gain an understanding of the processes used by critical care nurses in the early recognition of patient problems. Presence: The nurse presences in order to" make a connection" with the patient and the situation. Be alert to and act on this embodied knowledge.	Acting on knowing, advocate= outcomes Recognize subtle signs- combine with small changes in clinical values Nurses were able to "make a connection" in a matter of minutes- relationship over time not essential to assessment of subtle patient changes Negative case also highlighted in" missing the connection" All forms of knowing should be valued and discussed to assist novices and advanced beginners in valuing this practice
Moore, K. (2002) Caring behaviours of advanced practice nursing students. Journal of holistic Nursing 21 (1) 36-51 Caring APN students	Qualitative Content Analysis N=68 Advanced practice nursing students USA	To identify the meaning of caring from APN students' perspective. Presence: Being present provides time for the caring process to unfold Presence recognized as an intervention Presence without harm	Nine themes: Physical care Communication Comfort Presence Knowing Acceptance Touch Collaboration Encouragement
Nelms, T. (1996) Living a caring presence in nursing: a heideggerian hermeneutical analysis. Journal of Advance Nursing 24 (3) 368-374 Caring Nurses	Qualitative Hermeneutical Content Analysis N=5 USA	To understand more fully the phenomena of caring. Presence:" Silent call of conscience to authentic being was "heeded by each one of the nurses in the study." The nurses experienced "Gelassenheit" (Heidegger) – the openness where being- both their being and the being of others – reveals itself.	Constitutive pattern: Care as the presencing of being

Author *Article*	*Method* *Sample* *Country*	*Purpose of Study* *Description of Presence*	*Results* *Comments*
Usher, K. & Monkley, D. (2001) Effective communication in an intensive care setting: Nurses' stories. Contemporary Nurse. 10 (1) 91-101 Communication Critical Care Nurses	Qualitative Interviews N=4 Intensive Care Unit Nurse Experts (Identified by peer group as expert communicators) Australia	To explore the nurses' perceptions of effective communication with patients in an intensive care unit. Presence: Presencing was identified as one of three themes arising from the data. Defined using a Heideggerian philosophy. Experts spoke of "sensing" and "knowing" in getting through to and understanding semi-conscious patients.	Three Themes: • Nurses' perceptions • Presencing • Reassurance
Walter, A. (1995) A heidggerian hermeneutic study of the practice of critical care nurses. Journal of Advanced Nursing. 21 (3) 492-497 Caring Critical Care Nurses	Qualitative Interviews Hermeneutical N=8 clinical nurse specialists in ICU Australia	To interpret the caring experiences of nurses working in an Austrailian Intensive Care Unit. To describe the caring processes. Presence: Recognition that in an ICU there is potential to lose dignity and be treated in a dehumanizing way. ICU nurse can bring knowledge of the patient's personhood to the decision-making process. The nurse as an authentic being. One nurse – one patient fosters a physical closeness that enhances understanding of the personhood and the experiences of these patients.	Themes and subcategories: Being busy- one nurse, one patient Pace of the work Balancing Organizing the bed area Caring with technology
Walker, A. (2002) Safety and comfort work of nurses glimpsed through patient narratives. International Journal of Nursing Practice. 8 (1) 42-48 Safety and Comfort Patients	Qualitative Grounded Theory N= 17 Medical- Surgical patients, purposive sample Australia	To understand the safety and comfort work of nurses as perceived by patients. Presence: Safety- seemed sometimes overt and unobtrusive to the point where informants were unaware of the significance of the nurses' action. Comfort- dominant issue was the affective and interpersonal comfort work of nurses. Many nurses were not too busy to incorporate comforting into their styles.	Being treated with dignity was comforting From a patient perspective nurses are judged by their human qualities and interaction skills (no reference point for technical competence) Negative cases examined: Pt felt alone Hazardous to health

Appendix D
Inclusion Criteria

Inclusion Criteria

1. Nurses who have practiced in critical care nursing (see operational definitions Chapter 2) for five years or more
2. Nurses who may have held leadership positions in the Intensive Care Unit (ICU) such as care facilitator (team leader) or mentor
3. Nurses who may have been identified as expert on their last performance review or who meet the definition outlined below

Expert critical care nurse

An expert ICU nurse has specialized knowledge and skill in the science and the art of ICU nursing. This specialized knowledge and skill has developed over time as the result of practice and exposure. "The expert nurse perceives the situation as a whole, uses past concrete situations as examples and moves to the accurate region of the problem without wasteful consideration of a large number of irrelevant options" (Benner,1984, p. 295). In comparison, the competent nurse must rely on conscious, deliberate, analytical problem solving.

The expert ICU nurse relies on intuitive grasp as defined by Benner (1984) to make clinical judgments. Intuitive grasp allows a "holistic understanding that bypasses building the situation up element by element" (Benner, 1984, p.295). These inclusion criteria were shared with the unit educators and clinical nurses who were involved in identifying study participants by the snowball or nominated sampling method (Morse, 1991).

Appendix E
Letters of Support

The Ottawa Hospital | L'Hôpital d'Ottawa

DEPARTMENT OF CRITICAL CARE / DÉPARTEMENT DE SOINS CRITIQUES

Wendy Fortier
Clinical Director, Critical Care
The Ottawa Hospital

Feb 2005
Dr.R. Saginur
Chair, The Ottawa Hospital Ethics Board

Dear Dr. Saginur,

This letter is in support of the MScN student thesis proposal "A Grounded Theory Study of How Professional Nurses Develop and Practice Nurse Presence in a Critical Care Unit", submitted by Abigail Hain.

It is anticipated that this research will contribute to the education of novice critical care nurses. The student research work will be completed under the guidance of a three-member thesis committee, chaired by Dr. J.Logan from the School of Nursing, the University of Ottawa.

Sincerely

W Fortier

Wendy Fortier,
Clinical Director, Critical Care
The Ottawa Hospital

☒ ***CIVIC CAMPUS CIVIC***
1053 av. Carling Avenue
Ottawa, Ontario K1Y 4E9
Telephone: (613) 798-5555 Ext. 16405
Fax: (613) 761-5418

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The Ottawa Hospital | L'Hôpital d'Ottawa

DEPARTMENT OF CRITICAL CARE / DÉPARTEMENT DE SOINS CRITIQUES

Johane Bedard
Manager ICU, Critical Care
The Ottawa Hospital

March 2005
Dr.R. Saginur
Chair, The Ottawa Hospital Ethics Board

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Johane Bedard
Clinical Manager, General Site
The Ottawa Hospital

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DEPARTMENT OF CRITICAL CARE / DÉPARTEMENT DE SOINS CRITIQUES

Mike Langill
Clinical Educator, Critical Care
The Ottawa Hospital

Feb 2005
Dr.R. Saginur
Chair, The Ottawa Hospital Ethics Board

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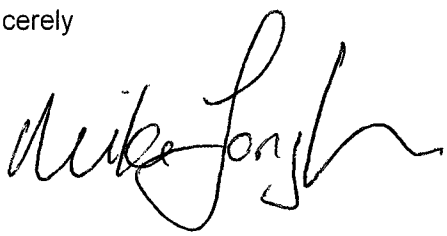
Sincerely



Mike Langill,
Clinical Educator, Critical Care
The Ottawa Hospital

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The Ottawa Hospital | L'Hôpital d'Ottawa

DEPARTMENT OF CRITICAL CARE / DÉPARTEMENT DE SOINS CRITIQUES

Sue Malone-Tucker
Clinical Educator, ICU, General Site
The Ottawa Hospital

Feb 2005
Dr.R. Saginur
Chair, The Ottawa Hospital Ethics Board

Dear Dr. Saginur,

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Sincerely

Sue Malone-Tucker,
Clinical Educator, ICU, General Site
The Ottawa Hospital

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The Ottawa Hospital | L'Hôpital d'Ottawa

DEPARTMENT OF CRITICAL CARE / DÉPARTEMENT DE SOINS CRITIQUES

Sharon Slivar
Clinical Educator, ICU, General Site
The Ottawa Hospital

Feb 2005
Dr.R. Saginur
Chair, The Ottawa Hospital Ethics Board

Dear Dr. Saginur,

This letter is in support of the MScN student thesis proposal "A Grounded Theory Study of How Professional Nurses Develop and Practice Nurse Presence in a Critical Care Unit", submitted by Abigail Hain.

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Sincerely

Sharon Slivar,
Clinical Educator, ICU, General Site
The Ottawa Hospital

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Appendix F
Ethics Approval

The Ottawa Hospital | L'Hôpital d'Ottawa

Research Ethics Board
Conseil d'éthique en recherches
798-5555 ext 14146, 14902 or 15072
Fax No. ~ 761-4311
http://www.ohri.ca/ohreb/

Monday, June 13, 2005

Ms. Abigail Hain
Ottawa Hospital - Civic Campus
Division of Critical Care
F2
1053 Carling Avenue
Ottawa, ON K1Y 4E9

Dear Ms. Hain:

Re: Protocol # 2005360-01H **A Grounded Theory Study of How Expert Professional Nurses Develop and Practice Nurse Presence in a Critical Care Unit**

Protocol approval valid until - Monday, June 12, 2006

I am pleased to inform you that your study (listed above), the Protocol submitted 04/05/2005, the English Letter of Invitation, and the English Consent Form were given expedited review by the Ottawa Hospital Research Ethics Board (OHREB) and are approved. No changes, amendments or addenda may be made in the protocol without the OHREB review and approval.

The validation dated should be indicated on the bottom of all consent forms and information sheets (see copy attached). Approximately two months prior to the expiration date listed above, a single renewal form should be sent to the OHREB office.

The Tri-Council Policy Statement requires a greater involvement of the OHREB in studies over the course of their execution. You must inform the Board of adverse events encountered during the study, here or elsewhere, or of significant new information which becomes available after the Board review, either of which may impinge on the ethics of continuing the study. The OHREB will review the new information to determine if the protocol should be modified, discontinued, or should continue as originally approved.

Yours sincerely,

R.A. Saginur

Raphael Saginur, M.D.
Chairman
Ottawa Hospital Research Ethics Board

Encl.

/cb

Appendix G
Letter of Invitation

The Ottawa Hospital | L'Hôpital d'Ottawa

Letter of Invitation

A study of how professional nurses develop and practice nurse presence in a critical care unit

Principle Investigator: Abigail Hain RN, MScN (candidate)
School of Nursing, University of Ottawa
(613) 747-3720

Supervisor: Dr. Jo Logan RN, Ph.D
School of Nursing, University of Ottawa
(613) 562-5800, ext. 8415

Reason for Study

I am a Registered Nurse in the Master of Science in Nursing (MScN) program at the University of Ottawa. I am conducting a research study to understand how nurses in the Intensive Care Unit (ICU) are able to provide care that connects with their patients. The purpose of this study is to understand how nurses develop and practice nurse presence in the ICU. Nurse presence has been described as "connecting with a patient", "going beyond the scientific data" and "being in tune with a patient's messages". Your participation may increase our understanding of how nurses develop and use this skill in ICU. It is hoped that an increased understanding of nurse presence will contribute to the education of new ICU nurses.

What is involved

Either the educators, the manager of your unit or your peers have identified you as an expert ICU nurse with experience and skill in the area of patient interaction and an interest in being involved in nursing research. If you choose to participate I will interview you about your experience with presence in caring for your patients in ICU. A sample question asked by the researcher will be "Tell me about a time when you noticed a connection with a patient that meant a lot you." The interview will be tape recorded, will last approximately 45 minutes long and will take place at a time and place convenient to you. The interview will be offered in English only as the interviewer is not fluent in French.

Follow-up

I will mail a copy of your interview with some interpretative themes once I have reviewed our interview. I will then contact you by phone one time to compare how I have understood your experience to your own interpretation. The follow-up phone call will last approximately 15-20 minutes. Providing your home address for this follow-up will be an option for you.

Risks and Benefits

We do not anticipate any risks for people who participate in this study. You may feel free to stop your participation at any time if you become tired, uncomfortable or have any other concerns. You will receive no payment for your participation. There may be no direct benefit to you as a participant in this study. You may enjoy the opportunity to talk about nursing experiences that have meant a lot to you over your career in ICU.

Voluntary Participation

Your participation in this study is voluntary. Your decision to withdraw from the study or decline participation will not influence your employment at the Ottawa Hospital. You are free to withdraw from the study at any time without affecting your employment now or in the future. You will receive a copy of the signed consent if you choose to participate in the study.

Confidentiality

The cassette tapes from our interview will be closed coded so that no identifying information will be on the cassette. Any identifying information, such as your name will not be given, to maintain confidentiality. The information in this study may be published in professional journals, but your identity will be protected with pseudonyms and no mention of the hospital's name. I will be the only researcher who will have access to your identity. The student's thesis committee will have access to your data, which will remain confidential with a code number and a pseudonym. Cassette tapes, transcripts and signed consent forms will be kept in locked files and destroyed by the researcher after two years from the time of your interview.

Contacts

If you wish to receive more information about this study, or have any questions, whether before or after the interview, you can contact Abigail Hain at (613) 747-3720 or the researchers thesis advisor Dr.J.Logan at the School of Nursing, the University of Ottawa, 562-5800 ext 8415. If you have any questions about your right as a research participant, you may contact the Chairperson of The Ottawa Hospital Research Board at 798-5555 ext 14902.

Participation

If you are interested in being involved in this nursing research please contact Abigail Hain with a phone call at (613) 747-3720 or tear off this contact confirmation slip with your name and phone number, seal it in the supplied envelope and leave it with the educators or manager and I will contact you.

I would like to participate in this nursing research.

Name:

Phone Number:

Appendix H
Consent Form

The Ottawa Hospital | L'Hôpital d'Ottawa

Consent Form

A study of how professional nurses develop and practice nurse presence in a critical care unit

Principle Investigator: Abigail Hain RN, MScN (candidate)
School of Nursing, University of Ottawa
(613) 747-3720

Supervisor: Dr. Jo Logan RN, Ph.D
School of Nursing, University of Ottawa
(613) 562-5800, ext. 8415

Reason for Study

I am a Registered Nurse in the Master of Science in Nursing (MScN) program at the University of Ottawa. I am conducting a research study to understand how nurses in the Intensive Care Unit (ICU) are able to provide care that connects with their patients. The purpose of this study is to understand how nurses develop and practice nurse presence in the ICU. Nurse presence has been described as "connecting with a patient", "going beyond the scientific data" and "being in tune with a patient's messages". Your participation may increase our understanding of how nurses develop and use this skill in ICU. It is hoped that an increased understanding of nurse presence will contribute to the education of new ICU nurses.

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Confidentiality

The cassette tapes from our interview will be closed coded so that no identifying information will be on the cassette. Any identifying information, such as your name will not be given, to maintain confidentiality. The information in this study may be published in professional journals, but your identity will be protected with pseudonyms and no mention of the hospital's name. I will be the only researcher who will have access to your identity. The student's thesis committee will have access to your data, which will remain confidential with a code number and a pseudonym. Cassette tapes, transcripts and signed consent forms will be kept in locked files and destroyed by the researcher after two years from the time of your interview.

Contacts

If you wish to receive more information about this study, or have any questions, whether before or after the interview, you can contact Abigail Hain at (613) 747-3720 or the researchers thesis advisor Dr.J.Logan at the School of Nursing, the University of Ottawa, 562-5800 ext 8451.The Ottawa Hospital Research Ethics Board has approved this protocol. The board considers the ethical aspects of all hospital research projects using human subjects. You may contact the Chairperson of The Ottawa Hospital Research Ethics Board at 798-5555 ext 14902 if you have any questions about your rights as a research participant.

Signatures

I have read the above and consent to participate in this research study. I am aware that my participation is voluntary and that I can discontinue my involvement at any time. I will receive a copy of this consent form.

Participant's Signature Printed Name Date

The information within this consent has been explained to the participant, and to the best of my knowledge, the participant understands the nature of the study and the risks and benefits involved in the study.

Researchers Signature Printed Name Date

Consent Valid Until: _____

Appendix I
Semi-structured Interview Tool

Semi-Structured Interview Questions

Some nurses who talk about their experiences with patients have described being in tune with their patient. They have described these experiences as connecting with their patient and going beyond the scientific data. They have also described that "being with" patients in a connected way influences a patient's care. These nurses have indicated that these experiences have stood out for them in their nursing experience.

1. Can you tell me about a time when you noticed a connection with a patient that meant a lot to you?

   _ Can you describe where this occurred?

   _ What the patient's situation was?

   _ What did you do during this experience?

   _What was the result of this experience for the patient and for you (how did it make you feel)?

2. Describe to me a time when you made a decision to just "be with" a patient as part of your care in ICU. (may be a brief encounter or a prolonged one)

   _ Can you describe where this occurred?

   _ What the patient's situation was?

   _What preceded your decision to "be with" the patient? What motivated you?

   _ What did you do during this experience?

   _What was the result of this experience for the patient and for you (how did it make you feel)?

3. How often would you say you make the decision to "be with" your patient as part of your care?

   _Is the experience the same every time?

   _Is there something in common with the types of patients?

4. Can you describe how stay connected and in tune with a patient in your nursing practice in ICU?

5. How do you connect and stay in tune with your patient differently with your patients now than when you first started nursing in ICU?

6. How does connecting with your patient fit with all the technology in the ICU?

   _ How has your interaction with technology and your patient changed from when you first started nursing in ICU?

7. Can you describe a patient interaction that taught you about the nurse patient relationship in ICU?

8. Can you describe a time when it was difficult to connect with a patient? (added after three interviews were completed)

Appendix J
Information Letter With Member Check Mailing

The Ottawa Hospital | L'Hôpital d'Ottawa

How expert professional nurses practice and develop nurse presence in a critical care unit: A grounded theory study. Primary Investigator: Abigail Hain

Dear

Thank you very much for participating in the above mentioned study. It was a privilege to have shared some of your nursing experiences with you and I appreciated your time.

You will find enclosed in this package two abstracts that are a condensed version of the findings for the study. You will also find a diagram of a model that pulls together the experiences of the nine nurse participants included in the research.

I would like to touch base with you on the phone to ask if some, or all of the findings in the study resonate with your experience. Because the information included is brief I can describe a bit more to you in our phone conversation. The phone conversation would take about ten minutes. I will endeavor to connect with you when you are at work and not busy.

Once again thank you very much for your time with this study.

Yours truly,

☐ *Civic Campus Civic*
1053 av. Carling Avenue
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